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No. 04-___

IN THE

Supreme Court of the United States

MERCK & CO., INC.; UNUM LIFE INSURANCE COMPANY OF AMERICA; AND MERCK & CO., INC. LONG TERM DISABILITY PLAN FOR UNION EMPLOYEES,

Petitioners,

v.

CELESLIE EPPS-MALLOY,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether an ERISA plan fiduciary exercising discretionary authority to determine claims for disability benefits commits a "procedural irregularity" that results in decreased judicial deference to the fiduciary's benefits decision, merely because the fiduciary requests an independent medical examination in reviewing a claim that calls for medical judgment.

PARTIES TO THE PROCEEDING

Michaleen Kosiba and Celeslie Epps-Malloy were the plaintiffs in the district court. Ms. Epps-Malloy was the appellant in the Third Circuit. Ms. Kosiba settled her case in the district court and did not participate on appeal. Merck & Co., Inc., UNUM Life Insurance Company of America, and Merck & Co., Inc. Long Term Disability Plan for Union Employees were the defendants in the district court and the appellees in the Third Circuit.

RULE 29.6 DISCLOSURE STATEMENT

Merck & Co., Inc. is a publicly-traded corporation. UNUM Life Insurance Company of America is a wholly-owned indirect subsidiary of UnumProvident Corporation, which is a publicly-traded corporation. Merck & Co., Inc. Long Term Disability Plan for Union Employees is an employee welfare benefit plan.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners Merck & Co., Inc. ("Merck"), UNUM Life Insurance Company of America ("UNUM"), and Merck & Co., Inc. Long Term Disability Plan for Union Employees (the "Plan") respectfully petition this Court for a writ of certiorari to review the decision of the United States Court of Appeals for the Third Circuit, which involves an important question under the Employee Retirement Income Security Act of 1974 ("ERISA"): The impact of a plan fiduciary's request for an independent medical evaluation ("IME") on the arbitrary and capricious standard of review that otherwise would apply to the fiduciary's denial of benefits under *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

The Third Circuit's decision merits this Court's review. The court of appeals held that a request for an IME as part of the review of a disability benefits claim under an ERISA-governed plan constitutes a "procedural irregularity" that implies a conflict of interest and reduces a court's deference to the plan fiduciary's benefits determination. The decision rests on the assumption that IMEs are intrinsically unreliable or unfair—an assumption that this Court rejected in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003). The Third Circuit's decision also conflicts with decisions in other circuits that have held that the use of an IME is evidence of reasonableness and fairness in the evaluation of an ERISA claim and, conversely, that a failure to obtain an IME under some circumstances is evidence of unreasonableness and unfairness. This is the first circuit court decision to condemn and penalize a fiduciary for requesting an IME. It places administrators in the position of being "damned if they do and damned if they don't" when they consider obtaining IMEs as part of their review of claims involving medical issues. Compounding the dilemma for fiduciaries is the fact that current Department of Labor ("DOL") regulations governing ERISA claim procedures *require* benefit plans to consult with qualified health care professionals when considering claims that involve medical judgment. Certainly, a fiduciary's compliance with DOL regulations by requesting an IME cannot constitute a "procedural irregularity."

Petitioners respectfully request the Court to review the Third Circuit's decision and to restore uniformity in the lower courts by holding that a fiduciary's reasonable request for an IME during the ERISA claim review process is not a "procedural irregularity" that supports an inference of a conflict of interest. This holding will give claim fiduciaries exercising discretionary authority the necessary latitude to decide when to use IMEs in order to comply with DOL claim procedure regulations. It will further enable those fiduciaries to fully and fairly review benefit claims, and to protect

plan assets from dissipation due to the approval of meritless claims.

OPINIONS BELOW

The district court's unpublished memorandum opinion, dated December 27, 2001, is reproduced in the Appendix to this petition ("App.") at 21a. The opinion of the Third Circuit is reported at 384 F.3d 58 and reproduced at App. 1a.

JURISDICTION

The judgment of the Third Circuit was entered on September 13, 2004. The Third Circuit denied a timely petition for rehearing and rehearing en banc on October 27, 2004. Petitioners invoke the jurisdiction of this Court under 28 U.S.C. § 1254(1) (2000).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Section 404(a)(1) of ERISA, 29 U.S.C. § 1104(a)(1) (2000), defines an administrator's basic fiduciary duties under the Act. Section 503(2), *id.* § 1133(2), requires every plan to afford participants a reasonable opportunity to appeal adverse benefit determinations to the plan fiduciary. The DOL enacted 29 C.F.R. § 2560.503-1 to implement Section 503(2). In 1997, when Ms. Epps-Malloy internally appealed from UNUM's denial of her claim, that regulation required every plan to establish a procedure by which a claimant could obtain a full and fair review of a claim denial. 29 C.F.R. § 2560.503-1(g) (1997). The current regulation further provides that where a determination of a claim for benefits requires medical judgment, the fiduciary, in deciding an administrative appeal, must consult with a qualified health care professional in the relevant field of medicine. 29 C.F.R. § 2560.503-1(h)(3)(iii) (2004), *incorporated in* 29 C.F.R.

§ 2560.503-1(h)(4) (2004). These statutory and regulatory provisions are set forth at App. 65a through 68a.

STATEMENT OF THE CASE

Factual Background. Ms. Epps-Malloy, who worked in a Merck cafeteria, was a participant in the Plan, for which Merck acts as the plan administrator and UNUM acts as the claims administrator. The Plan gives Merck discretionary authority to construe the terms and provisions of the Plan and to determine claims. Merck delegated that authority to UNUM, as the Plan permitted. Court of Appeals Appendix ("C.A. App.") 368-69, 403. The Plan provides benefits for participants who are disabled from performing their regular jobs for Merck for the first 24 months of long-term disability, and continuing benefits thereafter for those participants who are disabled from any gainful occupation for which the employee is reasonably qualified. The Plan provides for the termination of benefits when the participant is no longer totally disabled.

Regarding IMEs, the Plan states:

> The Administrator, as often as may be reasonably required, shall have the right to require any employee receiving a benefit under this Plan to undergo a medical examination by a physician or physicians designated by the Administrator and to provide other evidence of continuing disability . . . .
>
> [T]he Plan Administrator and Claims Administrator shall have the right and opportunity, at their own expense, to examine any person when and so often as they may reasonably require during the pendency of a claim for benefits hereunder.

Id. at 371, 372.

In 1991, after a workplace injury, Ms. Epps-Malloy did not return to work. Thereafter, she was approved for long-term

disability benefits, retroactive to November 1991, subject to periodic reevaluations to determine her continued eligibility.

In 1996, after Ms. Epps-Malloy had been paid short- and long-term benefits for five years, UNUM requested updated medical information from her then-current treating physicians in order to review her disability status. Based on the perceived inadequacy of the medical evidence—in particular, her doctor's reliance exclusively on a test conducted over six years earlier to support his diagnosis of sarcoidosis[1]—UNUM concluded that Ms. Epps-Malloy was no longer totally disabled. Therefore, Merck ceased paying benefits in December 1996.

In January 1997, Ms. Epps-Malloy appealed the termination and submitted a treatment note from a physician whom she had consulted for the first time a week earlier, after receiving UNUM's termination letter. While the new doctor reported Ms. Epps-Malloy's subjective complaints regarding "respiratory distress" and concluded that she had "severe sarcoidosis" and could not return to gainful employment, his treatment note failed to reflect objective testing to confirm her subjective complaints and to support the sarcoidosis diagnosis. C.A. 467. After a UNUM staff nurse questioned the validity of the conclusions reached in the January 1997 treatment note, UNUM requested Ms. Epps-Malloy to appear for an IME by a pulmonology specialist.

Based on the results of objective tests, the IME doctor "ha[d] a difficult time ascribing sarcoidosis as a cause of her

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[1] Sarcoidosis is a disease that causes inflammation of the body's tissues. According to the United States Department of Health and Human Services, it "usually is a mild condition and does not result in lasting harm to tissues," and "even those who need treatment can usually lead a normal life." *Facts About Sarcoidosis*, National Institute of Health Publication No. 02-5060 (April 2003), *available at* http://www.nhlbi.nih.gov/health/public/lung/other/sarcoidosis/sarcoid.pdf.

symptomatology." Rather, in his view, Ms. Epps-Malloy "appear[ed] to be somewhat emotional," and he could "not reliably exclude her malingering behavior." Ultimately, he concluded "based on her pulmonary function tests and arterial blood gas information, that her present diagnosis [of sarcoidosis] is incompatible with her clinical presentation." *Id.* at 481.[2] Relying on the IME, UNUM adhered to its decision to terminate benefits.

Proceedings Below. In challenging the termination of benefits, Ms. Epps-Malloy invoked the jurisdiction of the district court under 29 U.S.C. §§ 1132(a)(1)(B), 1132(e), and 1132(f) (2000), and under 28 U.S.C. § 1331 (2000). In lieu of a bench trial, the district court made findings of fact and conclusions of law based upon the stipulated administrative record, the parties' trial briefs, and oral argument.

The district court applied an arbitrary and capricious standard of review to UNUM's termination decision because the Plan confers discretionary authority. App. 40a-41a, 47a-48a. The court rejected the argument that Merck had an inherent conflict due to its dual roles as plan administrator and funding source and, therefore, that a heightened standard of review applied. *Id.* at 41a-47a. Relying principally on the 1997 IME, the court found substantial evidence in support of UNUM's determination that Ms. Epps-Malloy was no longer totally disabled, *id.* at 51a; therefore, it held that the termination decision was not arbitrary and capricious, and it ordered dismissal of Ms. Epps-Malloy's claims. *Id.* at 57a, 63a-64a.

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[2] Some of Ms. Epps-Malloy's earlier medical reports included diagnoses of fibromyalgia in addition to sarcoidosis. The district court did not address the evidence related to the fibromyalgia diagnosis, and, therefore, the Third Circuit remanded for a new trial on that issue. App. 16a-18a. Petitioners do not seek this Court's review of that particular ruling of the Third Circuit.

The Third Circuit reversed on the basis that the district court had erred in applying an unmodified arbitrary and capricious standard of review. Initially, after a lengthy discussion of the possibility of a conflict of interest based on Merck's roles as both plan administrator and funding source, the court concluded that the record was insufficient to establish a conflict and to "impose a heightened standard of review on this ground." *Id.* at 13a-14a. However, the Third Circuit stated that "demonstrated procedural irregularity, bias, or unfairness in the review of the claimant's application for benefits" is an independent "cause for heightened review." *Id.* at 12a-13a. Acknowledging that the court never before had reduced deference based exclusively on the presence of a procedural irregularity, *id.* at 13a, the panel did so in this case—based solely on UNUM's and Merck's request that Ms. Epps-Malloy submit to an IME. *Id.* at 14a-16a. The court did not find any procedural irregularity in the *performance* of the IME. It held only that the request itself was improper. *Id.* at 15a.

Because the Third Circuit held that the district court had applied too deferential a standard of review, it remanded for a new trial under a "moderately heightened arbitrary and capricious standard," without reaching the merits of Ms. Epps-Malloy's claim. *Id.* at 16a. The court denied Petitioners' petition for rehearing and rehearing en banc. App. 19a.

REASONS FOR GRANTING THE WRIT

In *Firestone*, this Court held that courts generally should review a denial of benefits for abuse of discretion when the controlling plan vests the fiduciary with "discretionary authority to determine eligibility for benefits or to construe the terms of the plan." 489 U.S. at 115. The Court further noted, however: "Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a

'facto[r] in determining whether there is an abuse of discretion.'" *Id.* (quoting Restatement (Second) of Trusts § 187, comment d (1959)). That single sentence, which is all that the Court said on the subject in *Firestone*, has yielded enormous disagreement among the courts of appeals over what type of conflict reduces the deference otherwise due to ERISA benefit determinations by fiduciaries with discretionary authority.[3]

Some circuits have held that "procedural irregularities" in the benefits claim process constitute evidence of such a conflict and may result in less deference to a fiduciary's decision under *Firestone*, at least where the irregularity "caused a serious breach of the plan administrator's fiduciary duty" and "'has some connection to the substantive decision reached.'" *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160-61 (8th Cir. 1998) (citation omitted). In this case, the Third Circuit took this principle to a new level by condemning UNUM for requesting an *independent* medical examination as part of its reevaluation of Ms. Epps-Malloy's claim for continued long-term disability benefits. Without questioning the bona fides of the IME itself, the court deemed the mere *request* for the independent examination a "procedural irregularity" that required departure from the arbitrary and capricious standard of review.

The Third Circuit's decision adds to the confusion that already exists among the circuit courts as to what circumstances will alter what would otherwise be a deferential standard of review. Fiduciaries routinely use IMEs, particularly in evaluating health and disability claims. Under the current regime, the same administrator making the same

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[3] In a separate petition filed concurrently with the instant petition, UNUM is requesting the Court to grant certiorari review of the Tenth Circuit's decision in *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997 (10th Cir. 2004), in order to clarify this aspect of *Firestone*.

claim decision under the same employee benefit plan can be subject to different review standards, and potentially different results, depending on where a suit for benefits is filed. In every other circuit that has addressed the issue, reliance on an IME is evidence that a conflict of interest does not exist or that a denial was not arbitrary and capricious, while in the Third Circuit, the same reliance will heighten review of a benefits denial, as if a conflict does exist. Given ERISA's rather generous venue provisions, one can expect disappointed claimants to forum-shop in order to seek the body of law that gives them the best chance of prevailing. But fiduciaries of benefit plans should not be forced to make claim determinations, including decisions about whether to request IMEs, in this fractured environment.

One purpose of ERISA was to encourage employers to adopt employee disability plans, which are not required by law but which greatly benefit disabled employees and society as a whole. The Third Circuit's ruling, which permits a fiduciary to adequately investigate some claims only if it foregoes the full degree of discretion that otherwise would attach to its claim decisions, will increase employers' costs and will discourage the provision of health welfare benefits, contrary to Congress' goal of increased adoption of such plans. Petitioners respectfully request this Court to grant review and resolve the circuit split by holding that a request for an IME is not evidence of a conflict of interest and does not dilute the deference otherwise owed to a fiduciary's benefits determination under *Firestone*.

I. THE THIRD CIRCUIT'S DECISION, WHICH PRESUMES BIAS FROM A FIDUCIARY'S REQUEST FOR AN IME AND THUS GIVES REDUCED DEFERENCE TO A DENIAL OF BENEFITS, CONFLICTS WITH DECISIONS OF THIS COURT AND OTHER FEDERAL COURTS OF APPEALS.

An IME is just that—an independent evaluation of a claimant's medical condition. In the context of a claim for disability benefits, an IME is often used, as in this case, to help the fiduciary determine whether the claimant meets the plan's definition of "disability." An IME may be employed because the submitted medical support for the claim is controverted, ambiguous, or incomplete—as the Third Circuit conceded it was in this case, App. 15a. A fiduciary also may request an IME where the medical evidence, though consistent, warrants additional consideration, including by a specialist. *See, e.g.*, *Stratton v. E.I. DuPont de Nemours & Co.*, 363 F.3d 250, 257-58 (3d Cir. 2004) (affirming denial of health benefits where treating physician's report fully supported claim, but IME reached different conclusion); *Donato v. Metro. Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994) (same).[4]

In *Black & Decker*, the Court held that fiduciaries may rely on the views of "consultants retained by a plan," including on IMEs, in lieu of deferring to treating doctors' opinions on questions of disability. 538 U.S. at 832. The Court made

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[4] Fiduciaries administering ERISA-governed medical plans also often rely on IMEs to evaluate benefits claims. For example, IMEs can be critical in determining whether particular treatments are experimental or medically necessary. *See, e.g.*, *Ortlieb v. United Healthcare Choice Plans*, 387 F.3d 778, 783-84 (8th Cir. 2004); *Barnett v. Kaiser Foundation Health Plan, Inc.*, 32 F.3d 413, 415-16 (9th Cir. 1994).

clear that there is nothing intrinsically unreliable or unfair about IMEs and, hence, no inherent impropriety in their use:

> [T]he assumption that the opinions of a treating physician warrant greater credit than the opinions of plan consultants may make scant sense when, for example, the relationship between the claimant and the treating physician has been of short duration, or when a specialist engaged by the plan has expertise the treating physician lacks.

Id.[5]

Even before *Black & Decker*, the courts of appeals had consistently recognized the benefits of IMEs in assessing health and disability benefit claims under ERISA. As well-stated by the First Circuit, "[a]nalyzing disability claims plainly requires expertise. It is, therefore, difficult to fault a plan administrator for seeking expert assistance (indeed, it probably would be easier to fault a plan administrator for not seeking such assistance)." *Leahy v. Raytheon Co.*, 315 F.3d 11, 16 (1st Cir. 2002). According to the Seventh Circuit, "[s]eeking independent expert advice is evidence of a thorough investigation," and, therefore, fiduciaries act appropriately when they make reasonable IME requests. *Hightshue v. AIG Life Ins. Co.*, 135 F.3d 1144, 1148 (7th Cir. 1998). Indeed, every other circuit that has considered the use of IMEs has concurred that they *add value* to, rather than detract from, an initial benefit determination and review on internal appeal. *See infra* at 18-20. *Cf.*, *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 383-84 (2002) (state laws that require second opinion before health insurers may deny coverage "ensure sound medical judgments").

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[5] Significantly, Ms. Epps-Malloy's relationship with Dr. McQueen, the physician whose report prompted the IME, had been "of short duration." *See* C.A. 467 (note reflecting only one examination of Epps-Malloy one week after UNUM terminated her benefits); *see also* App. 6a.

The DOL also has embraced IMEs as a means of ensuring fairness and accuracy in claims calling for medical judgments. Under a regulation adopted in 2001, the DOL now requires that under ERISA, "*in deciding an appeal* of any adverse benefit determination that is based in whole or in part on a medical judgment . . . *the appropriate named fiduciary shall consult with a health care professional* who has appropriate training and experience in the field of medicine involved in the medical judgment." 29 C.F.R. § 2650.503-1(h)(3)(iii) (2004), *incorporated in* 29 C.F.R. § 2650.503-1(h)(4) (2004) (emphasis added). The DOL adopted this regulation in order "to ensure full and fair review of benefit denials." *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488, 2502 (2004); *see also* 65 Fed. Reg. 70246, 70252 (Nov. 21, 2000) (regulation adopted "new standards [including requirement of consultation with independent health care professional] for a full and fair appeal of an adverse benefit determination"); Dept. of Labor, Employee Benefits Security Administration, *Frequently Asked Questions About the Benefit Claims Procedure Regulation*, D-8 (Sept. 4, 2002) ("EBSA FAQS"), *available at* http://www.dol.gov/ebsa/FAQS/faq_claims_proc_reg.html ("This requirement of consultation is intended to ensure that the fiduciary deciding a claim involving medical issues is adequately informed as to those issues.").

There is no question that the DOL regulation contemplates the use of IMEs in assessing disability claims. The agency has confirmed that "[m]any plans, including group health and disability plans, require claimants to submit to examination by an expert or experts of the plan's choosing in connection with the plan's consideration of the claimant's claim," and that the only limitation on such IME requests is that they

must occur in time to conform to the time frames stated in the 2001 regulation. EBSA FAQS C-4; *see also id.* at D-8, D-9.[6]

The DOL is the agency delegated by Congress to enforce ERISA and, in particular, to enact regulations to govern fiduciaries' review of claims. *See* 29 U.S.C. § 1002(13) (2000) (defining "Secretary" as the Secretary of Labor); *id.* § 1133 (requiring plans to conform to "regulations of the Secretary" governing claims procedures). The DOL regulation, which recognizes that IMEs often will be necessary in order to ensure the "integrity of the decision making process," 63 Fed. Reg. 48390, 48401 (Sept. 3, 1998), is entitled to deference from the courts. *See Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 844 (1984).

Consistent with the DOL regulations, and like virtually all ERISA-governed disability and health plans, the Plan expressly permitted UNUM and Merck to request Ms. Epps-Malloy to submit to an IME in order to evaluate whether her disability was continuing. *See supra* at 4. Absent that right, fiduciaries would be hostage to the views of claimants' treating physicians, a result that conflicts directly with *Black & Decker*.

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[6] Other federal agencies have confirmed the value of IMEs in evaluating disability claims. *See, e.g.*, 20 C.F.R. § 404.1593(c) (2004) ("A consultative examination may be purchased when [the Social Security Administration] need[s] additional evidence to determine whether or not [a claimant's] disability continues."); 32 C.F.R. § 536.8(b) (2004) (in cases against the Department of the Army "in which there is an allegation of temporary or permanent disability, the claimant should be examined by an independent physician"). Virtually all states include some form of IME requirement in their workers' compensation and disability compensation schemes. *See, e.g.*, Alaska Stat. § 23.30.095(e) (2004); Cal. Labor Code § 4616.4 (West 2004); Cal. Code Regs. tit. 22, § 2627(c)-1 (2004); Ga. Code Ann. § 34-9-310 (2004); N.H. Rev. Stat. Ann. § 281-A:38 (2004).

Beyond the regulatory support and contractual basis for the IME request in this case, an ERISA fiduciary has a duty to all beneficiaries to preserve plan assets—including by scrutinizing claims carefully and declining claims that do not qualify under the plan. That duty serves the "common interest" of beneficiaries and employers alike in ensuring "the financial integrity of the plan." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 142 n.9 (1985). "The common law of trusts recognizes the need to preserve assets to satisfy future, as well as present, claims and requires a trustee to take impartial account of the interests of all beneficiaries." *Varity Corp. v. Howe*, 516 U.S. 489, 514 (1996) (citation omitted). Under these guiding principles, "[a] company failing to conduct proper inquiries into claims for benefits breaches its duties to all claimants as a fiduciary of the benefit funds when it grants claims to unqualified claimants." *Barnhart v. UNUM Life Ins. Co. of Am.*, 179 F.3d 583, 589 (8th Cir. 1999) (citation omitted); *see also Woolsey v. Marion Labs., Inc.*, 934 F.2d 1452, 1458 (10th Cir. 1991) ("ERISA requires that the Plan be administered with an eye solely to the best interests of all the beneficiaries."); *de Nobel v. Vitro Corp.*, 885 F.2d 1180, 1191 (4th Cir. 1989) ("Fiduciaries are obligated to act not only in the best interests of beneficiaries, but with due regard for the preservation of trust assets."). A fiduciary frequently "act[s] prudently on behalf of all beneficiaries by not accepting at face value the medical evidence as submitted by [the claimant], but by conducting a further inquiry into her claims of disability." *Barnhart*, 179 F.3d at 589.[7] Indeed, benefits determinations are at the heart of the discretion committed to ERISA fiduciaries, who must balance the interests of present claimants against the interests of

[7] Of course, fiduciaries are not required to request IMEs in all cases. For example, an internal medical review might be sufficient to evaluate the claim or the claim might turn on a question of policy interpretation, not medical judgment.

future claimants who benefit from the denial of meritless claims.

A. The Third Circuit's Decision Conflicts with This Court's Decision in *Black & Decker*.

The Third Circuit purported not to condemn IMEs in the abstract, ruling instead only that "the circumstances under which Merck made th[e] request" for an IME in *this* case "necessarily raise an inference of bias." App. 14a. In fact, because none of the identified circumstances calls into question Merck's and UNUM's good faith in soliciting an IME from Ms. Epps-Malloy, the Third Circuit's supposedly narrow holding is actually sweeping in scope:

- The fact that Ms. Epps-Malloy's "physician's [sic] reports uniformly supported her contentions," App. at 15a, proves nothing about the legitimacy of the IME request. Reasonable IME requests are appropriate whenever the fiduciary believes that additional review by a doctor other than the claimant's treating physician or the fiduciary's in-house medical staff would assist in determining a claim, regardless of the uniformity of the treating physicians' reports. *See supra* at 10-11.
- Similarly, the timing of the IME—"not at the initial determination stage, but at the appeal stage," App. 15a—suggests no mischief. Under most ERISA plans, the "appeal stage" is a critical part of the claim consideration process, and fiduciaries encourage claimants to submit additional medical evidence. *See* Dept. of Labor, Employee Benefits Security Administration, *What You Should Know About Filing Your Health Benefits Claim*, *available at* http://www.dol.gov/ebsa/publications/ wyskfhbc.html (undated) ("When appealing a benefit denial, be sure to include any additional information or evidence supporting your claim . . . ."). As the Third Circuit acknowledged, in this case Ms. Epps-Malloy submitted "addi-

tional information" during the appeal, "including the name of her new treating physician." App. 6a. When a UNUM nurse questioned the sufficiency of that new medical information, UNUM and Merck requested an IME. That sequence of events cannot reasonably be read as suggesting impropriety.

- Finally, there was nothing nefarious about Merck's supposed "interven[tion]" into UNUM's claim review. App. 14a-15a. First, the only evidence of Merck's involvement is a brief reference to Merck's request for an IME in a single letter from UNUM. C.A. 478. More to the point, Merck had a right to make this request. The Plan expressly provided that Merck and UNUM "shall have the right and opportunity, at their own expense, to examine any person when and so often as they may reasonably require during the pendency of a claim for benefits hereunder." *Id.* at 372.[8]

Setting aside these benign circumstances, all that is left to support the Third Circuit's inference of procedural irregularity is the fact of the IME request itself. But that inference is unwarranted unless IMEs are intrinsically partisan. And that assumption—on which the Third Circuit's conclusion fundamentally rests—is wrong as a matter of fact, law, and policy.

The Third Circuit's decision makes precisely the sort of assumption that this Court held impermissible in *Black & Decker*—"that the opinions of a treating physician warrant greater credit than the opinions of plan consultants." 538 U.S. at 832. The court of appeals has done exactly what this Court has said that courts may not do—"impose on plan

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[8] At oral argument in the district court, the parties agreed that Merck requested an IME "to give Ms. Epps-Malloy another chance," C.A. 123, at a time when UNUM was "ready to discontinue her right then and there" based on its in-house nurse's review of the medical record. *Id.* at 121. In other words, Ms. Epps-Malloy did not share the adverse inference the Third Circuit drew from Merck's role in the claim review process.

administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation." *Id.* at 834.

Significantly, the Third Circuit's decision condemns UNUM's request for an IME without identifying a single deficiency in the evaluation itself. There is no hint of bias by the physician whom UNUM retained, no suggestion that he was unqualified to assess Ms. Epps-Malloy's condition, no intimation that the IME was a tool of harassment, and no evidence that the conclusions reached were not medically valid and reliable.

Perhaps most disturbing, by increasing the judicial scrutiny imposed on UNUM's and Merck's discretionary benefits decisions, the Third Circuit has penalized Petitioners for nothing more than the exercise of their contractual right to request an IME, their legal duty to perform an appropriate medical review in administrative appeals, and their fiduciary duty to all participants to protect the Plan's assets by ensuring the validity of an individual's claim.

Although the Third Circuit says that it "trust[s] that courts will not penalize plan administrators for seeking independent medical examinations at appropriate stages of the claims determination process," App. 16a, that is indeed what the court of appeals' decision does. It compels fiduciaries to choose between "collect[ing] enough information to make a responsible claims determination" and "avoid[ing] requesting more information in the hopes of maintaining the most deferential standard of review." *Id.* But this is a Hobson's choice: Under the Third Circuit's decision, abuse of discretion standard of review mandated in *Firestone* for discretionary benefits decisions applies only if fiduciaries rubber-stamp the opinions of treating physicians in contravention of *Black & Decker* and the current DOL regulations, and only if they pay claims without regard to fairness and accuracy, in contravention of their duties to all participants.

B. The Third Circuit's Decision Conflicts with Decisions in Other Circuits.

Among the courts of appeals, the Third Circuit stands alone in inferring procedural bias from a request for an IME. The First Circuit has specifically refused to "fault a plan administrator for seeking expert assistance," *Leahy*, 315 F.3d at 16, and therefore it declined to heighten the standard of review, based exclusively on an administrator's use of IMEs:

> We are aware of no case holding that a plan administrator operates under a conflict of interest simply by securing independent medical advice to aid in the evaluation process. Nor do we view this as an accident: common sense dictates that retaining outside physicians to assist in evaluating disability claims, without more, does not constitute a conflict of interest.

Id.

Exercising similar logic, other courts of appeals have held that (a) a fiduciary's reliance on an IME neutralizes or, at least, mitigates an administrator's structural conflict, or conversely, (b) a failure to obtain an IME evidences a bias that may decrease judicial deference. *E.g.*, *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1015 (10th Cir. 2004) ("Where, as here, a conflict of interest may impede the plan administrator's impartiality, the administrator best promotes the purposes of ERISA by obtaining an independent evaluation."); *Woo*, 144 F.3d at 1161 (applying less deferential review where "Hartford denied Woo's claim without seeking any independent medical review"); *Hightshue*, 135 F.3d at 1148 ("[P]rovided that the fiduciary has investigated the expert's qualifications, has provided the expert with complete and accurate information, and determined that reliance on the expert's advice is reasonably justified under the circumstances, the fiduciary's decision will be respected, despite the conflict of interest."); *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 234 (4th Cir. 1997) ("MetLife's [inherent] conflict of

interest . . . was greatly mitigated by its substantial reliance on the evaluations of the independent Roundtable"); *Donato*, 19 F.3d at 380 n.3 (resort to two IMEs vitiated inherent conflict); *cf.*, *Morgan v. UNUM Life Ins. Co. of Am.*, 346 F.3d 1173, 1177 (8th Cir. 2003) ("In some circumstances, the administrator's use of an in-house physician rather than a[n outside] specialist to review a disability claim involving an uncommon disease can be a serious procedural irregularity affecting the administrator's decision.") (citations omitted).

The courts of appeals also have uniformly cited a fiduciary's use of an IME as evidence of reasonableness and fairness in the evaluation of claims—and, conversely, have identified the failure to obtain an IME as evidence of unreasonableness and unfairness. *See, e.g.*, *Williams v. BellSouth Telecomms., Inc.*, 373 F.3d 1132, 1139 (11th Cir. 2004) (affirming denial of benefits under either *de novo* or arbitrary and capricious standard of review, where administrator "thoroughly reviewed medical evidence concerning Williams's condition, including that of an IME"); *House v. Paul Revere Life Ins. Co.*, 241 F.3d 1045, 1048 (8th Cir. 2001) (insurer "was entitled to require House to submit to an [IME] and . . . would have been entitled to discount [the treating doctor's] opinion entirely in favor of a contrary opinion produced by the independent examiner"); *Sweatman v. Commercial Union Ins. Co.*, 39 F.3d 594, 601-03 (5th Cir. 1994) (no abuse of discretion where MetLife, *inter alia*, "contracted independent medical consultants to evaluate [plaintiff's treating physician's] records and determine whether they supported her physical limitations"); *Madden v. ITT Long Term Disability Plan for Salaried Employees*, 914 F.2d 1279, 1286 (9th Cir. 1990) (evidence, including fiduciary's reliance on "an independent outside service, to assess Madden's benefit claim," established reasonableness and impartiality of its decision); *cf.*, *Todd v. Aetna Health Plans*, 31 Fed. Appx. 13 [2002 WL 257364 at *1] (2d Cir. 2002) (though finding no abuse of discretion in Aetna's

failure to seek an IME, characterizing its conduct as "highly questionable in light of the indications of Todd's disability").[9]

In short, the conflict between the Third Circuit's decision and the law of every other circuit that has reached the IME issue could not be more pronounced.[10]

II. THE IMPACT OF AN IME REQUEST ON THE ERISA STANDARD OF REVIEW IS A RECURRING ISSUE OF NATIONAL IMPORTANCE TO CLAIMANTS, EMPLOYERS, AND FIDUCIARIES.

The interest in uniformity. In enacting ERISA, Congress sought to foster a "uniformity of decision" to "help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws." S. Rep. No. 93-127, at 29 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4865. Congress wanted to "ensure that plans and plan sponsors would be subject to a uniform body of benefits law" so as to "minimize the administrative and financial burden of complying with conflicting direc-

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[9] Indeed, the Third Circuit's decision conflicts even with that court's own precedent. For example, in *Abnathya v. Hoffman-La Roche, Inc.*, 2 F.3d 40 (3d Cir. 1993), the court relied largely on two IMEs for its holding that the denial of benefits was not arbitrary and capricious. *Id.* at 47-48; *see also Stratton*, 363 F.3d at 257 (affirming denial where administrators, *inter alia*, had independent physician "review the information submitted [by plaintiff's treating physician] before finally denying Stratton's request").

[10] The Third Circuit's analysis conflicts with decisions of other courts in another, related respect. Those courts that have deemed a procedural irregularity to be a basis for reducing deference to a fiduciary's benefits determination have required "material, probative evidence, beyond the mere fact of the apparent irregularity, tending to show that the administrator breached his fiduciary obligation." *Buttram v. Central States, S.E. & S.W. Areas Health & Welfare Fund*, 76 F.3d 896, 900 (8th Cir. 1996). The Third Circuit's decision, however, mandates no such inquiry.

tives," *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)—"burdens ultimately borne by the [plan's] beneficiaries," *Egelhoff v. Egelhoff*, 532 U.S. 141, 150 (2001). However, "[u]niformity is impossible" if different courts subject plans to "different legal obligations." *Egelhoff*, 532 U.S. at 148. *See also Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987) ("uniform administrative scheme" intended under ERISA would be "difficult to achieve" if a plan were required "to process claims in a certain way in some States but not in others").[11]

The Third Circuit's decision defeats Congress' goal of uniformity. By equating an IME with procedural bias, the Third Circuit creates a difficult practical problem for fiduciaries. Under the cases of almost every other circuit, administrators facing medical judgments have either an incentive or obligation to avail themselves of IMEs. In the Third Circuit alone, they do so at their peril—at the risk of losing the deference that the plan documents, the law of trusts, and *Firestone* otherwise would compel.

The decision below leaves ERISA plan fiduciaries in a quandary as to when they may, should, or must rely on IMEs. Administrators of plans governing employees in multiple federal circuits, as under the Plan in this case, must either establish diverse claim review protocols based on geography alone, or accept heightened review based solely on their appropriate resort to independent analysis of claims raising difficult questions of medical judgment.

The interest in uniformity on this issue is great. Fiduciaries should not be forced to operate under two mutually-exclusive claim processing protocols—one of which is based not on

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[11] The cited cases all considered the need for uniform law in the context of preemption under ERISA of varying state laws. The underlying interest in uniformity, however, applies equally to the federal courts' application of the Act.

"best practices," but rather, on the views of a single federal court. The burden is particularly onerous on national employers like Merck, which review claims by employees in every federal circuit.

Absent clarification by this Court, the Third Circuit's holding will be costly for plans, whose assets will be drained through the payment of invalid claims that will not be tested through IMEs, where appropriate. It will lead to forum-shopping under ERISA's liberal venue provision, which permits the filing of suit to recover benefits "in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found." 29 U.S.C. § 1132(e)(2) (2000).[12] And it will be confusing and inequitable to participants.

The interest in accurate and fair claims procedures. A fundamental purpose of ERISA is to ensure that claim determinations are made fairly and accurately. Toward that end, the Act requires plans to provide for explanations of claim denials and for "full and fair review" of denials. 29 U.S.C. § 1133 (2000). ERISA also creates a civil cause of action "to recover benefits due" to plan participants. *Id.* § 1132(a)(1)(B).

The Third Circuit's decision will frustrate the paramount public interest in fair and accurate claim determinations by penalizing fiduciaries for using an often-essential resource for evaluating claims – the IME. DOL claim procedures, enacted for the purpose of enforcing ERISA's fairness requirement, recognize the need for claim administrators to obtain advice

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[12] The courts have construed the "may be found" language as providing for venue in any district in which the defendant has minimum contacts sufficient to establish personal jurisdiction. *See I.A.M. Nat'l Pension Fund, Benefit Plan A v. Wakefield Indus., Inc.*, 699 F.2d 1254, 1257-58 (D.C. Cir. 1983); *Varsic v. United States Dist. Court for the Central Dist. of Cal.*, 607 F.2d 245, 248 (9th Cir. 1979).

from medical professionals when benefits claims involve issues of medical judgment. The Third Circuit's decision fundamentally interferes with fiduciaries' obligations under these regulations. The current DOL regulations apply to claims filed on or after January 1, 2002, after termination of Ms. Epps-Malloy's benefits. However, the regulations confirm that in deciding appeals, fiduciaries *must* evaluate claims involving medical issues by consulting with medical experts. The only choice is whether to consult with an in-house medical professional, where such an individual is available, or to consult with an IME doctor. If UNUM had limited its analysis to review by an in-house physician, the Third Circuit presumably would not have questioned its fairness. Indeed, UNUM did ask a staff nurse to review the file and the Third Circuit voiced no criticism of that decision. Certainly, UNUM's decision to obtain the independent views of an outside specialist rather than relying solely on its employees' views should not be held against the company.

The interest in encouraging ERISA plans. "Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995). Well aware of this freedom, Congress cautioned that plans should not be so heavily burdened by regulation that "employers respond . . . by decreasing benefits under existing plans or slowing the rate of formation of new plans." H.R. Rep. No. 93-807, at 15 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4670, 4682. Yet, the Third Circuit's punishment of fiduciaries for availing themselves of IMEs runs counter to "the public interest in encouraging the formation of employee benefit plans." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987).

Specifically, by making IMEs unavailable unless the plan foregoes deferential review of its claim decisions, the Third Circuit's decision will lead to the approval of some non-

meritorous claims that would not otherwise be approved, and *should not* be approved. The approval of invalid claims, in turn, will render plans more costly. *See* 65 Fed. Reg. at 70260 ("limiting access to inappropriate care" enhances insurers' "abilities to effectively control costs"). The inevitable result is that some employers will either reduce the coverage provided under their plans or will decline to offer those benefits at all.

Moreover, the Third Circuit's unique condemnation of IMEs requires fiduciaries administering national plans to follow different procedures for claims that might end up in litigation in that circuit—at least, if they wish to preserve the arbitrary and capricious standard of review that would otherwise apply to their determinations. But "the administrative and financial burden of complying with conflicting directives," *Ingersoll-Rand*, 489 U.S. at 142, can be expected to encourage employers to cut back on ERISA-governed plans, or to discourage employers from adopting those plans in the first instance. "A patchwork scheme of regulation . . . introduce[s] considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax*, 482 U.S. at 11; *see also Varity*, 516 U.S. at 497 (recognizing Congress' "desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place") (citations omitted).

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted, and the judgment of the Third Circuit reversed.

Respectfully submitted,

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January 24, 2005

APPENDIX A

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

[Filed September 13, 2004]

No. 02-2668

MICHAELEEN KOSIBA; CELESLIE EPPS-MALLOY,

v.

MERCK & COMPANY; UNUM LIFE INSURANCE COMPANY OF AMERICA; and MERCK & CO., LONG TERM DISABILITY PLAN FOR UNION EMPLOYEES,

Celeslie Epps-Malloy,

Appellant

On Appeal From The United States District Court
For The District of New Jersey
(D.C. No. 98-cv-03571)
District Judge: Honorable Mary Little Cooper
Argued June 28, 2004

Before: AMBRO, BECKER, and GREENBERG, *Circuit Judge*

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OPINION

BECKER, *Circuit Judge.*

Plaintiff Celeslie Epps-Malloy is a former employee of defendant Merck & Co. ("Merck"), who participated in Merck's ERISA-based Long Term Disability Plan for Union Employees (the "Plan").[1] At times relevant, Merck, as overall plan administrator, had delegated responsibility for claims administration to defendant UNUM Life Insurance Company of America ("UNUM").[2] Following an at-work injury and a diagnosis of sarcoidosis and fibromyalgia, Epps-Malloy applied for and received long-term disability (LTD) benefits from the defendants in 1993. During a periodic review conducted in 1996, the defendants terminated Epps-Malloy's benefits, finding that she was no longer totally disabled under the terms of the Plan. During the course of the Plan's administrative appeals process, Merck requested that Epps-Malloy undergo an independent medical examination, and designated a pulmonologist, Dr. Gautam Dev, to evaluate her. Dr. Dev's report contradicted Epps-Malloy's treating physicians' diagnoses, and on this basis the defendants upheld their denial of continued benefits. Epps-Malloy then filed this suit under 29 U.S.C. § 1132(a)(1)(B), seeking benefits allegedly due her under the terms of the Plan.

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[1] Michaleen Kosiba, the other named plaintiff in this case, settled her case against the defendants in the District Court, and is not participating on appeal.

[2] We shall refer to Merck, the Plan, and UNUM collectively as "the defendants" except where it is necessary to distinguish them.

Epps-Malloy's claim survived summary judgment, and the District Court held a Fed. R. Civ. P. 52(a) bench trial on a stipulated documentary record. The Court concluded that under *Pinto v. Reliance Standard Life Insurance Co.*, 214 F.3d 377 (3d Cir. 2000), and its progeny, the structural arrangement among Merck, the Plan, and UNUM did not warrant a departure from the traditional "arbitrary and capricious" standard of review over ERISA plan fiduciaries' discretionary decisions regarding benefits. Turning to the merits of Epps-Malloy's claim, the District Court found, principally because of Dr. Dev's report, that the defendants' denial of benefits was not arbitrary and capricious.

On appeal, we concentrate on the District Court's first conclusion. We agree with the District Court that the record in this case does not support finding a financial conflict of interest (which, under *Pinto's* "sliding scale" approach, would warrant a standard of judicial review less deferential than arbitrary and capricious review), and that delegation by Merck to UNUM of claims administration would ordinarily preclude heightened review. However, there is evidence of procedural bias in Merck's intervention in the appeals process to request an independent medical exam. This is especially problematic because the record before the defendants prior to Dr. Dev's examination provided reasonably sound as well as unequivocal support for Epps-Malloy's claim for benefits; the choice to request a third medical opinion therefore strongly suggests a desire to generate evidence to counter Epps-Malloy's physicians' diagnoses. Because Merck's intervention, notwithstanding its delegation of claims administration to a large and experienced carrier, undermines the defendants' claim to the deference normally accorded an ERISA plan fiduciary with discretionary authority, we conclude that the District Court should have applied a moderately heightened arbitrary and capricious standard of review. Additionally, with respect to the merits, the District Court failed to address Epps-Malloy's fibromyalgia diagnosis, an omission

which itself alone would require a new trial. For these reasons, we will reverse the judgment of the District Court and remand for a new trial.

I. Factual Background and Procedural History

Although the District Court, which rendered its opinion following a Fed. R. Civ. P. 52(a) bench trial on a stipulated documentary record, gave a lengthy account of the parties' factual contentions, it by and large did not make findings of fact as required by Rule 52(a). As such, what follows is not so much the District Court's factual findings as it is our own summary of the record before us.

A. Epps-Malloy's Medical History

Epps-Malloy was employed by Merck as a cook and food-service attendant. She suffered an injury at work in 1991, and was diagnosed with fibromyalgia, chronic pain syndrome, and sarcoidosis.[3] She was granted short-term disability benefits by the defendants in October 1992. In October 1993, she was approved for LTD benefits, but was reminded that periodic requests for medical information would be made in the future to ensure continued eligibility (i.e., to determine that she continued to be completely disabled under the Plan).

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[3] It is unclear from the record whether there was any causal relationship between the injures—a stack of food service trays falling on Epps-Malloy—and the ailments that form the basis of her claim. Fibromyalgia (also referred to as fibromyositis) is "any of a group of nonarticular rheumatic disorders characterized by pain, tenderness, and stiffness of muscles and associated connective tissue structures." *Merriam-Webster Medical Dictionary* (2002), *at* http://www.dictionary.com. The cause is unknown. Sarcoidosis is "a disease of unknown origin marked by formation of granulomatous lesions that appear especially in the liver, lungs, skin, and lymph nodes." *American Heritage Stedman's Medical Dictionary* (2002), *at* http://www.dictionary.com. A granuloma, in turn, is a "[c]hronic inflammatory lesion characterised by large numbers of cells of various types (macrophages, lymphocytes, fibroblasts, giant cells), some degrading and some repairing the tissues." On-line Medical Dictionary, *at* http://cancerweb.ncl.ac.uk/ omd/index.html.

Around the same time, Epps-Malloy applied for Social Security disability benefits. In 1994, an administrative law judge overruled the Social Security Administration's (SSA) initial determination denying her Social Security benefits, and awarded her Social Security long-term disability benefits, finding her permanently disabled.

Epps-Malloy's benefits were provided under the terms of the Merck & Co. Long Term Disability Plan for Union Employees, an ERISA plan. By the Plan's terms, "[Merck] shall pay the cost of the benefits provided under the Plan," though the Plan gives discretion to the Management Pension Investment Committee to choose "any funding method, or combination of funding methods which are permissible under ERISA." The District Court found that no evidence was introduced on how Merck actually funded the plan, and the parties do not dispute this on appeal. The Plan allocates fiduciary responsibility among a committee of Merck's Board of Directors (which has certain powers of appointment); the Merck Management Pension Investment Committee (which is responsible for the investment and management of Plan funds); and Merck itself, which is the plan administrator. As plan administrator, Merck has the power to appoint a claims administrator, who "shall determine claims for benefits by Participants under the Plan." At the time Epps-Malloy's LTD benefits were first granted, Thomas L. Jacob & Associates ("TLJ") was Merck's appointed claims administrator; later, appellee UNUM was the claims administrator. Notwithstanding this appointment, the Plan confers on Merck (as plan administrator) the powers "to construe the Plan"; "to decide all questions of eligibility"; and "to request and receive from all Participants such information [as is] necessary for the proper administration of the Plan."

B. Termination of Epps-Malloy's LTD Benefits

In May 1996, as part of a periodic review of Epps-Malloy's benefits, UNUM requested information from her treating phy-

sicians, Dr. Panullo and Dr. David Williams. Dr. Panullo was Epps-Malloy's gynecologist. Epps-Malloy's disability is not related to any gynecological condition, so Dr. Panullo's reports are irrelevant—though they seem to have been misunderstood by UNUM, at some points, to indicate that Epps-Malloy was entirely able to work, when they in fact say only that no gynecological problems prevented Epps-Malloy from working. We therefore say no more about Dr. Panullo.

Dr. Williams's notes from January 16, 1996, refer to Epps-Malloy's sarcoidosis and her fibromyalgia. According to his notes, the sarcoidosis had been diagnosed by a 1989 bronchoscopy; the record does not disclose when the initial fibromyalgia diagnosis was made. Dr. Williams's June 14, 1996, notes state that "[s]arcoidosis is her diagnosis as well as fibromyalgia," and he indicated that she was being medicated for fibromyalgia. In response to an UNUM questionnaire dated October 28, 1996, Dr. Williams stated that Epps-Malloy was "disabled to light activity because of shortness of breath" and that his prognosis for her to return to gainful employment on a part-time basis or full-time basis was "never."

UNUM informed Epps-Malloy on December 31, 1996 that it was terminating her benefits. The letter explained that a review of medical documentation, including information from Drs. Panullo and Williams, led UNUM to conclude that she no longer met the definition of being "unable to perform any and every duty" of her occupation, as required by the Plan. The letter also stated that "there is no evidence to support that you are medically incapable to perform the duties of your occupation." The letter further informed Epps-Malloy that she would have to come forward with objective medical evidence of her disability.

Epps-Malloy administratively appealed this decision. She provided additional information to UNUM, including the name of her new treating physician, Dr. Fred McQueen. Dr.

McQueen repeated the fibromyalgia diagnosis, stated "[s]he cannot return to gainful employment," and that he did "not feel it in her best interest to be under any stress due to triggering her sarcoid remission." Dr. McQueen concluded: "Permanently & totally disabled. Suffers with severe anxiety. She cannot cope with stress."

Upon receiving Dr. McQueen's report, UNUM wrote to Epps-Malloy stating that "Merck & Company has requested an Independent Medical Exam." The defendants designated Dr. Dev to perform the examination. We rescribe Dr. Dev's report in the margin;[4] in sum, Dr. Dev concluded that a diag-

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[4] I saw Celeslie Epps-Malloy on 5/8/97. The patient is a 47 year old female with a history of sarcoidosis reportedly diagnosed by a transbronchial biopsy in 1987. The patient currently presents for medical evaluation for her complaints of shortness of breath on minimal exertion and also complains of cough, which is non-productive and worse upon laying down. The patient also has post-nasal drip and chronic sinus problems. Her exercise tolerance is minimal, and she is barely able to achieve her day-to-day activities. The patient was treated in the past with steroids; however, could not tolerate them because of what appears to be psychosis and marked degree of weight gain. She has a history of smoking one pack per day for six years.

> [Physical exam reveals nothing amiss; pulmonary function was normal; blood gases were near normal]
>
> My impression of Mrs. Epps-Malloy is that her symptomatology is not commensurate with her clinical presentation. Considering the normal pulmonary function test and near normal arterial blood gas, I have a difficult time ascribing sarcoidosis as a cause of her symptomatology. She appears to be somewhat emotional and I cannot reliably exclude malingering behavior. On the contrary, the endobronchial sarcoid may be leading to a persistent cough and dyspnea. Chronic sinusitis can also exacerbate a respiratory condition and lead to some degree of shortness of breath. The patient's impaired cardiac status is also a possibility and an exercise stress test might be able to help answer some of the unanswered questions.
>
> I feel, based on her pulmonary function tests and arterial blood gas information, that her present diagnosis is incompatible with her clinical presentation.

nosis of sarcoidosis was "incompatible with her clinical presentation"—i.e., that he disagreed with the sarcoidosis diagnosis. He did not opine on her fibromyalgia diagnosis. Based on Dr. Dev's report, UNUM upheld its decision denying benefits.

C. Proceedings Before the District Court

Epps-Malloy filed this suit, seeking benefits allegedly due her under the terms of the Plan under 29 U.S.C. § 1132 (a)(1)(B), and other relief. Merck counterclaimed to recoup, under the terms of the Plan, the Social Security disability benefits Epps-Malloy had received. The counterclaim was settled, and the District Court denied summary judgment on Epps-Malloy's § 1132(a)(1)(B) claim. The case therefore proceeded to a trial on the merits, which was conducted as a Fed. R. Civ. P. 52(a) bench trial on a stipulated documentary record. Canvassing *Pinto v. Reliance Standard Life Insurance Co.*, 214 F.3d 377 (3d Cir. 2000), and its progeny, the District Court first concluded that an "arbitrary and capricious" standard of review applied to its judicial review of the defendants' denial of benefits. The Court then concluded that their denial of benefits was not arbitrary and capricious. It therefore entered judgment for the defendants.

II. Our Standard of Review Over the District Court's Decision

In the post-*Pinto* era, we appear to have had only one case in the same procedural posture as this one, i.e., an appeal from a bench trial. In *Goldstein v. Johnson & Johnson*, 251 F.3d 433, 441 (3d Cir. 2001), we stated (without further elaboration or citation) that in such an appeal "[w]e have plenary review over a district court's conclusions of law, and

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Dr. Dev's description of when and how Epps-Malloy's sarcoidosis was first diagnosed conflicts with that of Dr. Williams; it is not clear whether this inconsistency is significant.

we review its factual conclusions for clear error." This is, of course, the usual standard of review on appeal from a bench trial. *See In re Unisys Savings Plan Litig.*, 173 F.3d 145, 149 (3d Cir. 1999). Determining the proper standard of judicial review under *Pinto* is a question of applying law to fact; accordingly, our review is plenary, though we review a district court's underlying factual findings only for clear error. Because we conclude the District Court applied too deferential a standard of judicial review, we do not reach the merits of Epps-Malloy's claim.

III. Standard of Judicial Review over Unum's Determination of Epps-Malloy's Claim

Our principal task is to determine whether the District Court applied the appropriate standard of judicial review to the defendants' decision to deny LTD benefits to Epps-Malloy. We begin with a discussion of *Pinto* and our cases following it, and then turn to the proper standard of judicial review in this case.

A. *Pinto* and Its Progeny

We held in *Pinto* that, in reviewing an ERISA plan fiduciary's discretionary determination regarding benefits, a court must take into account the existence of the structural conflict of interest present when a financially interested entity also makes benefit determinations. Specifically, we adopted a "sliding scale" approach, in which district courts must "consider the nature and degree of apparent conflicts with a view to shaping their arbitrary and capricious review of the benefits determinations of discretionary decisionmakers." *Pinto*, 214 F.3d at 393. This "sliding scale" method "intensif[ies] the degree of scrutiny to match the degree of the conflict." *Id.* at 379.

Pinto offered a nonexclusive list of factors to consider in assessing whether a structural conflict of interest warranting

heightened review exists. The sliding-scale approach "allows each case to be examined on its facts." *Id.* at 392. Among the factors we identified were "the sophistication of the parties, the information accessible to the parties, and the exact financial arrangement between the insurer and the company." *Id.* Also relevant is "the current status of the fiduciary," *id.*, i.e., whether the decisionmaker is a current employer, former employer, or insurer. Our cases have addressed various combinations of these factors. In *Pinto* itself, we concluded that "heightened arbitrary and capricious review," *id.* at 393, or review "on the far end of the arbitrary and capricious 'range,'" *id.* at 394, was appropriate because Pinto's insurer both made benefits determinations and funded the benefits, and because of various procedural anomalies that tended to suggest that "whenever it was at a crossroads, [the insurer defendant] chose the decision disfavorable to Pinto." *Id.*

Turning to *Pinto's* progeny, we first note that in some cases the parties stipulate to the applicable standard of judicial review, or at least do not contest the District Court's choice of a standard of review. *See, e.g., McLeod v. Hartford Fire & Accident Ins. Co.*, 372 F.3d 618, 623-24 & nn.3-4 (3d Cir. 2004); *Orvosh v. Program of Group Ins. for Salaried Employees of Volkswagen of Am., Inc.*, 222 F.3d 123, 129 (3d Cir. 2000). Other cases, though they cite *Pinto*, are factually too far removed from the facts of this case to provide meaningful guidance. *See, e.g., Goldstein*, 251 F.3d 433 (unfunded executive deferred compensation, or "top hat," plan).

While *Pinto* addressed the case of an insurer both making benefits determinations and paying claims, it did not definitively decide whether any form of heightened review applies to employers both making benefits determinations and paying claims. When an employer pays claims out of its general operating funds—the situation most likely to introduce a structural conflict because the employer feels an immediate "sting" from paying a claim—the plan is referred to as "un-

funded" or sometimes "self-funded." This is in contrast to "the typical employer-funded pension plan" which "is set up to be actuarially grounded, with the company making fixed contributions to the pension fund." *Pinto*, 214 F.3d at 388.

We confronted (but were ultimately able to avoid) ruling on the issue of whether heightened review applies to employers making benefits determinations and paying claims in *Skretvedt v. E.I. DuPont de Nemours & Co.*, 268 F.3d 167 (3d Cir. 2001). That case concerned (among other things) an employer-administered unfunded benefit plan, and noted that "a heightened standard of review might be applicable to the [employer-controlled] Board's denial of Skretvedt's claim for the unfunded . . . benefits, because of the potential conflict under *Pinto*." *Id.* at 175. We reached this question less than a year later, in *Smathers v. Multi-Tool, Inc./Multi-Plastics, Inc. Employee Health & Welfare Plan*, 298 F.3d 191 (3d Cir. 2002). In *Smathers*, we concluded that an employer's unfunded and self-adminstered benefits plan presented a conflict that, though "not extraordinary," did warrant "somewhat heightened" scrutiny, requiring "a more penetrating review of [the] administrator's decisionmaking process than would normally be conducted under the arbitrary and capricious standard." *Id.* at 199. Most recently, we approved a district court's holding that the unfunded and self-administered benefit plan in *Stratton v. E.I. DuPont de Nemours & Co.*, 363 F.3d 250, 255 (3d 2004), warranted only a "slightly heightened form of arbitrary and capricious review."

As we noted in *Pinto* itself, the financial and administrative relationship between the employer and the benefit plan is not the only relevant consideration. For example, in *Stratton*, we observed that while an employer administering an unfunded plan :nay have a financial incentive to deny the claims of its employees, it thereby risks "the loss of morale and higher wage demands that could result from denials of benefits." 363 F.3d at 254 (quoting *Nazay v. Miller*, 949 F.2d 1323,

1335 (3d Cir. 1991)); *see also Smathers*, 298 F.3d at 198; *Pinto*, 214 F.3d at 389. We have recognized the inverse as well: When a *former* employee seeks benefits, this conflict-mitigating consideration is not present. *See Smathers*, 298 F.3d at 198 ("Since Smathers was no longer an employee when Multi-Tool made its decision to deny his claims, the counterbalancing of its monetary self-interest by possible concerns about the impact of its decision on morale and wage demands would thereby be lessened.").

Indeed, we made the general point about the short-circuiting of incentives by imperfect information flow in *Pinto* itself:

> [M]any claims for benefits are made after individuals have left active employment and are seeking pension or disability benefits. Details about the handling of those claims, whether responsible or irresponsible, are unlikely to seep into the collective knowledge of still-active employees. If Pinto's claim is denied, few at Rhone-Poulenc will learn of it, and Reliance Standard will have little motive to heed the economic advice of the Seventh Circuit that "it is a poor business decision to resist paying meritorious claims for benefits."

214 F.3d at 388 (quoting *Mers v. Mariott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir, 1998)); *see also id.* at 392 (noting the relevance of the current relationship between the fiduciary and beneficiary). In short, our precedents recognize that the situation of an individual claiming benefits from her former employer may, for *Pinto* purposes, be more akin to that of an insured claiming benefits from an insurance company than that of an employee claiming benefits from her current employer.

Our precedents establish at least one more cause for heightened review: demonstrated procedural irregularity, bias, or unfairness in the review of the claimant's application for

benefits. The *Pinto* panel's decision to apply heightened review turned almost as much on the procedures afforded to Pinto as it did on her insurer's financial conflict of interest. *See Pinto*, 214 F.3d at 393 ("[L]ooking at the final decision, we see a selectivity that appears self-serving in the administrator's use of [one doctor's] expertise."); *id.* ("[i]nconsistent treatment of the same facts"); *id.* at 394 (suggesting that "whenever it was at a crossroads, Reliance Standard chose the decision disfavorable to Pinto"). Though no case since *Pinto* appears to have turned on evidence of procedural bias or unfairness, the corresponding negative pregnant appears in several of our cases. *See Skretvedt*, 268 F.3d at 175-76 (considering but rejecting allegations of decision-maker bias in the benefits review system); *Goldstein*, 251 F.3d at 435-36 (noting that heightened review would be required when "the beneficiary has put forth specific evidence of bias or bad faith in his or her particular case"); *Bill Gray Enters., Inc. Employee Health & Welfare Plan v. Gourley*, 248 F.3d 206, 216 (3d Cir. 2001) ("[U]nless specific evidence of bias or bad-faith has been submitted, plans . . . are reviewed under the traditional arbitrary and capricious standard."); *id.* at 216 n.8 ("Gourley has failed to allege bias on the part of the plan administrator . . . .").

B. The Appropriate Standard of Review in This Case

We begin with the financial and administrative arrangement between Merck and the Plan. The District Court found that Epps-Malloy had offered no evidence on the mechanism by which Merck funds the Plan beyond the bare statement in the Plan itself that "[Merck] shall pay the cost of the benefits provided under the Plan." By the Plan's terms, Merck is the plan administrator, and even though it has delegated claims administrative authority to UNUM, it exercises ultimate administrative authority as evidenced by its request that Epps-Malloy be examined by Dr. Dev. But since Epps-Malloy has not excluded the possibility that Merck pays for the benefits it

administers through fixed contributions to an actuarially grounded fund, thereby leaving Merck with no immediate financial conflict of interest, we do not impose a heightened standard of review on this ground.[5] We reiterate, however, our conclusion above that Epps-Malloy's status as a former employee might well trigger some heightened level of review if, for example, Merck pays Plan benefits out of its general operating funds.

Epps-Malloy's argument for heightened review draws more support from our discussion in *Pinto* of procedural bias. As described above, Merck intervened in Epps-Malloy's appeal process, requesting that she submit to an "Independent Medical Exam," ultimately conducted by Dr. Dev. Merck surely has the authority under the plan to require such an exam—the Plan empowers Merck as Administrator "to request and receive from all Participants such information [as is] necessary for the proper administration of the Plan." But the circumstances under which Merck made this request necessarily raise an inference of bias: At the time of the request, every piece of evidence in Epps-Malloy's record—the opinions of two doctors (Drs. Williams and McQueen), a consistent medical history, and an SSA determination that she

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[5] The District Court may, of course, allow the parties on remand to supplement the record to introduce evidence of the Plan's actual funding mechanism. While we have held that, in general, the record for arbitrary-and-capricious review of ERISA benefits denial is the record made before the plan administrator, and cannot be supplemented during litigation, *see Mitchell v. Eastman Kodak Co.*, 113 F.3d 433, 440 (3d Cir. 1997), when a court is deciding what standard of review to employ—arbitrary-and-capricious review, or some higher standard under *Pinto*—it may consider evidence of of potential biases and conflicts of interest that is not found in the administrator's record. The Plan's funding mechanism might well be evidence of this sort. *See, e.g., Stratton*, 363 F.3d at 254-55 (considering an ERISA plan's funding and decisionmaking mechanisms in deciding on a level of review); *Skretvedt*, 268 F.3d at 174-75 (same). We leave this decision to the sound discretion of the District Court.

was totally disabled—supported her contention that she was disabled.[6] The District Court's discussion is consistent with this view: It recognized that Epps-Malloy's physician's reports uniformly supported her contentions (though they were, in some aspects, incomplete), and that the defendants' denial of benefits was grounded on Dr. Dev's report, augmented by medical opinions offered by one Nurse Girardo based on a review of Epps-Malloy's file.

It is in this light that we must view Merck's request for an independent medical examination. We have a claimant seeking continued LTD benefits whose treating physicians offer unequivocal support for her claims, and a plan administrator that has delegated claims administration to a large insurance company intervening—not at the initial determination stage, but at the appeal stage—with a request for an additional medical examination to be performed by a physician of its own choosing. This situation arguably has a quality to it that undermines the administrator's claim to the deference normally owed to plan fiduciaries. Given how favorable the record was to Epps-Malloy prior to Dr. Dev's examination, the most natural inference is that by intervening and ordering the retention of Dr. Dev, thus seeking evidence to counter Epps-Malloy' s physicians' evaluation, Merck was not being a disinterested fiduciary.

That said, we acknowledge the possibility that Merck acted with a good faith belief that Epps-Malloy's application was a close call, and that it could resolve perceived ambiguities with a third physician's opinion. Independent medical examinations are not uncommon in the claims administration world, and this is responsible plan administration that we would not

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[6] We express no view on the relevance *vel non* in the ERISA benefits context of an SSA finding of total disability. It is enough for our purposes here to note that the SSA ruling gives at least some support for Epps-Malloy's claim for ER1SA benefits.

wish to deter. At this stage, however, we are considering only how searching a review of the defendants' benefits determination to undertake. Epps-Malloy's suit will rise or fall with the merits of her underlying claim (including Dr. Dev's opinion), modulated by the deference owed to the defendants' decision. For a responsible fiduciary, we trust that the incentive to collect enough information to make a responsible claims determination will outweigh the incentive to avoid requesting more information in the hopes of maintaining the most deferential standard of review. And we trust that courts will not penalize plan administrators for seeking independent medical examinations at appropriate stages of the claims determination process.

We conclude that the procedural bias we have described in Epps-Malloy's appeals process warrants a moderately heightened arbitrary and capricious standard of review. Naturally, a significantly heightened arbitrary and capricious standard of review would be warranted if Merck also acted under a financial conflict of interest, but, as noted above, the record before us does net demonstrate such a conflict. Because the District Court applied an unmodified arbitrary and capricious standard of review to the defendants' actions, we will set aside the judgment and remand for a new trial on the merits under an appropriate standard of judicial review. Because the question whether the defendants' determination can stand is essentially an ultimate issue of fact, it is appropriate for the District Court to undertake that inquiry in the first instance. *See* Fed. R. Civ. P. 52(a); *cf. Pullman-Standard v. Swint*, 456 U.S. 273, 287 (1982) (holding that clearly erroneous review applies to ultimate issues of fact as well as subsidiary findings of fact).

IV. The District Court's Conclusion on the Merits

Even if we were not setting aside the District Court's conclusion on the merits because of the standard of review it applied, we would be constrained to do so because it did not

adequately address the defendants' denial of LTD benefits to Epps-Malloy in light of her diagnosis of fibromyalgia. While one diagnosis in Epps-Malloy's records is sarcoidosis, she was also diagnosed with fibromyalgia. Not only did her doctors ascribe aspects of her disability to fibromyalgia, the ALJ appears to have granted SSA benefits to Epps-Malloy principally on the basis of her fibromyalgia. As noted above, Dr. Dev's report is the defendants' best counter to Epps-Malloy's physicians' diagnoses, but, as the District Court itself found, "[Dr. Dev] did not address the previous diagnosis of fibromyalgia or any other condition." This is hardly surprising, as Dr. Dev is a pulmonologist, and fibromyalgia is most commonly treated by a rheumatologist.

It would be premature to hold that, given the record on Epps-Malloy's alleged fibromyalgia, the defendants' denial of benefits to her was impermissible as a matter of law. Doctor Dev did, in fact, apparently perform a musculo-skeletal examination, finding "unremarkable" results; this may be evidence that Epps-Malloy was not disabled by fibromyalgia. But it is plain that the District Court did not adequately address the defendants' treatment of Epps-Malloy's fibromyalgia diagnosis. On remand, the District Court should separately consider the defendants' determinations regarding the two distinct infirmities from which Epps-Malloy allegedly suffers.

That Court's review of these determinations should be based on the record available to the plan administrator in making its own decision; if there is not sufficient evidence in the defendants' record to support their decision as to the fibromyalgia claim, then it must be reversed. *See Mitchell v. Eastman Kodak Co.*, 113 F.3d 433 (3d Cir. 1997); *cf. Sandoval v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 381 (10th Cir. 1992) ("In effect, a curtain falls when the fiduciary completes its review, and for purposes of determining if substantial evidence supported the decision, the district court

must evaluate the record as it was at the time of the decision."). While the District Court may take further evidence to aid in its understanding of the medical issues involved, it must base its ultimate determination on the record before the plan administrator, not its own judgment of whether Epps-Malloy was disabled. We leave it to the District Court to determine whether the defendants' treatment of Epps-Malloy's fibromyalgia claims met the moderately heightened arbitrary and capricious standard that we have identified.

V. Conclusion

Because the original bench trial proceeded on too deferential a standard of review, we will reverse the judgment of the District Court and remand for a new trial on the merits.

APPENDIX B

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 02-2668

MICHAELEEN KOSIBA; CELESLIE EPPS-MALLOY

v.

MERCK & COMPANY; UNUM LIFE INSURANCE COMPANY OF AMERICA; MERCK & CO., LONG TERM DISABILITY PLAN FOR UNION EMPLOYEES

Celeslie Epps-Malloy,
Appellant

Present: SCIRICA, *Chief Judge*, SLOVITER, NYGAARD, ROTH, RENDELL, BARRY, AMBRO, FUENTES, SMITH, CHERTOFF, FISHER, VAN ANTWERPRN, and BECKER,* *Circuit Judges*.

SUR PETITION FOR PANEL REHEARING WITH SUGGESTION FOR REHEARING *EN BANC*

The petition for rehearing filed by Appellant having been submitted to the judges who participated in the decision of this Court, and to all the other available circuit judges in active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted

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* Judge Becker as to panel rehearing only.

for rehearing by the court *en banc*, the petition for rehearing is DENIED.

BY THE COURT:
/s/ Edward R. Becker
Circuit Judge

DATED: October 27, 2004
par/cc: C.F.S., Esq.
P.J.H., Esq.

APPENDIX C

NOT FOR PUBLICATION

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

[Filed: December 27, 2001]

Civil Action No. 98-3571 (MLC)

MICHALEEN KOSIBA and CELESLIE EPPS-MALLOY,
Plaintiffs,

v.

MERCK & COMPANY, INC; UNUM LIFE INSURANCE COMPANY OF AMERICA; and MERCK & COMPANY, INC. LONG TERM DISABILITY PLAN FOR UNION EMPLOYEES,
Defendants.

MEMORANDUM OPINION

COOPER, *District Judge*

Plaintiff Celeslie Epps-Malloy ("Epps-Malloy") commenced this action on July 30, 1998 seeking relief under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461, against Merck & Company ("Merck"), UNUM Life Insurance Company of America ("UNUM"), and the Merck & Company, Inc. Long Term Disability Plan for Union Employees ("Merck Plan"). This matter is currently before the Court for a judgment on the pleadings regarding the termination of Epps-Malloy's long-term disability benefits. The Court is called upon to determine: (1) whether this termination is unlawful pursuant to 29 U.S.C. § 1132(a)(1)(B); and (2) whether, assuming the unlawfulness of the termination, all defendants are jointly and

severally liable to Epps-Malloy. In lieu of a formal bench trial, the parties were directed to submit trial briefs to the Court. The factual record consists of the pleadings and materials submitted in connection with defendants' summary judgment motion, which was denied in part and granted in part by a Memorandum and Order filed July 17, 2000 ("7-17-00 Memorandum and Order"). (Mem. & Order filed 7-17-00 ("7-17-00 Mem. & Order") at 1.) The Court has considered the submissions of the parties and heard oral argument on this matter. This Memorandum Opinion constitutes the Court's findings of fact and conclusions of law with respect to the issues currently before us pursuant to Federal Rule of Civil Procedure 52(a) ("Rule 52(a)").

For the reasons given in this Memorandum Opinion, the Court will grant judgment in favor of defendants on the grounds that the determination to terminate Epps-Malloy benefits did not violate the prevailing arbitrary and capricious standard of review. Judgment on the pleadings will therefore be entered in favor of the respective defendants as to the First, Second, and Third Causes of Action of the Second Amended Complaint. Because of the Court's resolution of the claims issue the Court need not consider the question of whether Merck and UNUM would be liable for any judgment in favor of Epps-Malloy.

BACKGROUND

Plaintiff was a cook and food service attendant at Merck. (Aff. of Celeslie Epps-Malloy filed 5-1-00 ("Epps-Malloy Aff.") ¶ 2.) Her general cafeteria duties included customer service, food preparation, stocking supplies, and certain cleaning responsibilities. (*Id.*) In May 1991, while she was putting trays in a server bin, several fell on her. (*Id.* ¶ 3.) Because of pain and swelling, she was unable to return to work. (*Id.*) At the time of the incident, Epps-Malloy was a participant in Merck's Long-Term Disability Plan for Union Employees (the "Plan"), which provides benefits to partici-

pating members who become disabled and are unable to perform the material aspects of their occupation. (Aff. of Gloria Dukes filed 4-24-00 ("Dukes Aff.") ¶¶ 2, 6.) To be eligible for benefits, a participant must: (1) complete the "Total Disability Eligibility Period;"[1] and (2) satisfy the definition of "Total Disability."[2] (*Id.* Ex. A: Merck & Co., Inc. Long-Term Disability Plan for Union Employees effective 1-1-97 ("Plan").) According to defendants, a participant has the burden to prove that he or she satisfies this definition of total disability.[3] (Dukes Aff. ¶ 8; Civil Action - Defs.' Trial Br. ("Defs.' Br.") at 4-5.) Under the Plan's administrative structure, Merck acts as the "Plan Administrator"[4] (Plan) and UNUM acts as the current "Claims Administrator"[5] (*id.*; Dukes Aff. ¶ 2). The Plan further

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[1] "The Total Disability Eligibility Period" is defined as "continuous Total Disability for 26 consecutive weeks." (Dukes Aff. Ex. A.)

[2] "Total Disability" during the Total Disability Eligibility Period and the first two years of benefit payments as "the complete and continuous inability of the Participant to perform any and every duty of the Participant's occupation." (Plan.) After that time, the Participant must be unable to "engage in any gainful employment for which the Participant is or may become reasonably qualified by education, training or experience." (*Id.*)

[3] The Plan required any employee "receiving a benefit under this Plan to undergo a medical examination by physician or physicians designated by the [Plan] Administrator and to provide other evidence of continuing disability." (Plan.)

[4] The "Plan Administrator" is the entity with "sole responsibility for the administration of the plan." (Plan.) It is responsible for making factual determinations and interpreting the Plan, as well as correcting and resolving any defects, omissions, inconsistencies, and questions, except as delegated to the Claims Administrator. (*Id.*) This entity is also responsible for deciding questions of eligibility and participation, except as so delegated. (*Id.*)

[5] The "Claims Administrator" makes "all determinations as to the right of any person to a benefit under the Plan." (Plan.)

provided that Plan benefits can be offset against other benefits, including Social Security disability payments.[6] (Plan.)

In April 1992, Epps-Malloy applied for benefits under the Plan.[7] (Certif. of Charles F.X. Szymanski filed 5-9-00 ("Szymanski Certif.") Ex. B: Employee's Application for Benefits dated 4-28-92.) Between April 1992 and September 1992, four medical professionals compiled separate reports regarding her condition.[8] (Epps-Malloy Aff. ¶¶ 7-11.)

When Epps-Malloy first filed for long-term benefits under the Plan, Thomas L. Jacobs and Associates ("TLJ") was responsible for claims administration. Since that time UNUM has assumed the role of Claims Administrator. (Dukes Aff. ¶ 2.)

[6] Plaintiff discusses her application for such Social Security benefits in her brief. (Civil Action - Trial Br. of Pl. Celeslie Epps-Malloy at 8-10.) For purposes of this matter currently before the Court, such details, with the exception of the administrative law judge's ruling discussed below, appear largely irrelevant and are not discussed herein. (*See* 7-17-00 Mem. & Order at 9-11.)

[7] Epps-Malloy also applied for workers' compensation benefits on the grounds of total and permanent disability. (Epps-Malloy Aff. ¶ 4.) Following an administrative trial including testimony from Epps-Malloy, Dr. Hermele, and Dr. Paul J. Kiell, her claim was settled. (Id.) According to Epps-Malloy, when she informed Anna Foster ("Foster"), a Merck representative, of this settlement, Foster informed her that she would still retain her employee status and continue to receive medical benefits until retirement without any loss of income. (Epps-Malloy Aff. ¶ 20.)

[8] Epps-Malloy's workers' compensation attorney, David Fiveland ("Fiveland") also referred Merck to reports prepared by Drs. Levandowski, Stein, and Falcone, which he claimed were already possessed by Merck. (Epps-Malloy Aff. ¶ 7 & Ex. E: Letter from David N. Fiveland to Merck & Co., Inc. dated 5-14-92.) None of these reports appear in the administrative record, and their contents are not emphasized by the parties in their arguments. According to Epps-Malloy, these three doctors were in Merck's employ. (Epps-Malloy Aff. ¶ 7.) She avers that Dr. Levandowski had been her treating physician for approximately one year, and he provided steroid injections. (*Id.*) Merck also paid for blood tests to be performed at the Kessler Institute. (*Id.*)

In a report dated April 15, 1992, Dr. Horia A. Schwartz ("Dr. Schwartz"), a physician apparently specializing in physical medicine and rehabilitation, gave the following diagnosis and opinion following an examination:

> Diagnosis: Permanent residuals of extensive musculoskeletal disorder with evidence of severe firbomiralgia, myofascitis, or in essence a myopathy. It is obvious that her condition has been probably precipitated by the stressful physical activity as well as by her specific underlying disorder, sarcoidosis.
>
> Commentary: Until a few years ago, it was considered that sarcoidosis was a disease of unknown ethology which is progressive in nature and would render a person totally disabled as time passes by. In the last few years, several articles have been written about connecting the sarcoidosis with stressful physical activities, but that was more on a "tentative" basis rather than specific proof. The bottom line is that anybody with an underlying diagnosis of sarcoidosis, whether or not they know about it or not, will have the entire spectrum of disability and symptomatology in a gradual and worsening fashion. It appears that in this particular instance that she developed the symptoms simultaneously with her being diagnosed as having sarcoidosis and it is entirely within the realm of medical probability that the type of work performed by her aggravated or precipitated the sarcoidosis. However, the sarcoidosis is not due to her trauma, although her "disorder" is definitely due to sarcoidosis.
>
> In conclusion, we have a relatively young woman who suffers with severe musculoskeletal disorder, essentially pathological joint disease, bowel syndrome, etc., all connected with sarcoidosis as well as aggravated by the physical work activities, which renders her at present totally disabled, from the orthopedic standpoint.

> It is highly unlikely that she will improve and that she will be able to do any kind of stressful physical activity in the future. Unless, of course, a new method of treatment is developed, either medical or otherwise, it is expected that she will progressively deteriorate. To what rate, nobody knows—it is strictly individual. In essence, Ms. Epps is no longer capable of working at her occupation or at any occupation that requires prolonged immobilization, such as even a sendentary position and definitely not in any occupation that requires physical activities.[9]

(Dukes Aff. Ex. G: Letter from Horia H. Schwartz, M.D. to David N. Fiveland, Esq. dated 4-15-92 ("Dr. Schwartz Report") at 2.)

Dr. Paul J. Kiell ("Dr. Kiell"), a neurologist who examined Epps-Malloy on April 28, 1992, concluded that she suffered from chronic pain syndrome and neuropsychiatric disability. (Szymanski Certif. Ex. E: Letter from Paul J. Kiell, M.D. to Kirsch et al. Esqs. dated 4-28-92 ("Dr. Kiell Report") at 2-3.) An independent medical examiner, Dr. Frederick D. Gangemi ("Dr. Gangemi"), examined Epps-Malloy on June 30, 1992 and found that she suffered from fibromyalgia and noted the possibility that this "myofasial pain syndrome" was related to stressful work activities."[10] (Szymanski Certif. Ex. G: Letter

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[9] Sarcoidosis is a granulomatous disease that causes inflammation in the lymph nodes, liver, eyes, lungs, skin and other tissues. *See, e.g.*, National Inst. of Health, U.S. Nat'l Library of Med. *Sarcoidosis*, http://www.nlm.nih.gov/medlineplus/articl /00076.htm (last visited Oct. 15, 2001). A treatment therapy can last for one or two years; however, some affected with the disease require lifelong therapy. *Id.*

[10] Fibromyalgia is a "common rheumatic syndrome indicating widespread pain in fibrous tissues, muscles, tendons and other connective tissues, resulting in painful muscles without weakness." Nat' Inst. of Health, U.S. Nat'l Library of Med., *Fibromyalgia*, http://nlm.nih.gov/medlineplus/ency/article/000427.htm (last visited Nov. 30, 2001). A key characteristic of this condition is long standing pain at specific tender

from Frederick D. Gangemi, M.D. to Thomas L. Jacobs & Associates, Inc. dated 7-17-92 ("Dr. Gangemi Report") at 2.) The report stated that, although physical therapy treatments would provide only short-term, temporary relief, an exercise program would reduce her pain and stiffness and give her an enhanced sense of well being. (*Id.* at 2-3.) Rik Couwenberg, P.T. ("Couwenberg"), performed a key functional capacity assessment on Epps-Malloy on September 4, 1992. (Szymanski Certif. Ex. H: Letter from Rik Couwenberg, P.T., to Thomas L. Jacob & Associates, Inc. dated 9-4-02 ("Couwenberg Report").) Couwenberg recommended that Epps-Malloy not return to work and stated that the prognosis for her attaining a "light physical demand classification" was poor if she in fact suffered from fibromyositis and given the past lack of success with physical therapy treatments.[11] (*Id.* at 4.)

In October 1992, Epps-Malloy learned that she was approved for long-term disability benefits. (Szymanski Certif. Ex. I: Letter from Jean J. Copp to Ms. Celeslie Epps-Malloy dated 10-9-92 at 1-2.) She was informed that she would receive benefits for twenty-four months if she remained totally disabled from returning to work. (*Id.*) After that two-year period, benefits would be extended upon a determination that she was disabled from any occupation she was reasonably qualified for "by education, training or experience." (*Id.*)

As the two-year limit approached, information was requested from Epps-Malloy's then-treating physician, Dr. Randolph Stein ("Dr. Stein") in March 1993. (Epps-Malloy

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points. *Id.* It is usually a benign condition causing no damage to connective tissue or muscles. Under a supportive treatment plan, prognosis is generally good, but symptoms can persist in certain cases. *Id.*

[11] Fibromyositis is defined as "chronic inflammation of a muscle with an overgrowth, or hyperplasia, of the connective tissue." Steadman's Medical Dictionary 649 (26th ed. 1995).

Aff. ¶¶ 15-16.) Dr. Stein diagnosed her with fibromyalgia as well as chronic pain syndrome. (Szymanski Certif. Ex. N: Attending Physician's Statement dated 3-23-93 ("Dr. Stein Report") at 1.) He reported that Epps-Malloy's symptoms included pain in her arm, shoulder, neck, back, hip, and buttock area and concluded that she had reached maximum medical improvement. (*Id.* at 1-2.)

Based on a review of her administrative record and a questionnaire completed by Epps-Malloy, Epps-Malloy was approved for extended benefits in October 1993. (Szymanski Certif. Ex. P: Letter from Corey Bulluck to Ms. Celeslie Epps dated 10-5-93; Dukes Aff. ¶ 17 & Ex. L: Transition Investigation Employee Questionnaire dated 6-30-93.) The letter notifying her of the extension explained that periodic requests for medical information or other documentation would be made in the future to ensure continued eligibility for benefits. (*Id.*)

Even before this approval of continuing benefits, Epps-Malloy applied for Social Security disability benefits on March 30, 1992. (Epps-Malloy Aff. ¶ 13.) The Social Security Administration denied this application on December 14, 1992. (*Id.*) On June 1, 1993, Epps-Malloy filed a request for a hearing before an administrative law judge. (*Id.*) This hearing was held on March 18, 1994, and the administrative law judge issued his decision on September 13, 1994 ("Social Security Decision"). (*Id.* ¶ 19; Szymanski Certif. Ex. Q: Decision dated 9-13-94 ("Social Security Decision").) The judge reversed the denial of benefits and found that Epps-Malloy satisfied the definition of disability under the Social Security Act. (Social Security Decision at 2-5.) Epps-Malloy recalls forwarding a copy of this decision to UNUM or the Merck Plan in September of 1994 as well as sending a facsimile to UNUM representative Daren Winckler in November of 1995. (Epps-Malloy Aff. ¶ 21; Szymanski Certif. Ex. R: Facsimile Transmission Cover Sheet.)

The administrative law judge found that, because Epps-Malloy could not perform a significant number of jobs in the national economy, she satisfied the definition of disability under the Social Security Act from May 14, 1991 until the date of the Social Security Decision. (Social Security Decision at 3-5.) He made a number of additional findings:

> 3. The medical evidence establishes that the claimant has severe chronic pain syndrome, sarcoidosis; by history, but that she does not have an impairment or combination of impairments listed in, or medically equal to one listed in Appendix 1, Subpart B, Regulations No. 4.
>
> 4. The intensity and persistence of the claimant's subjective complaints and alleged functional limitations are supported by the evidence.
>
> 5. The claimant has the residual functional capacity to perform the physical exertion requirements of work except for inability to lift over five pounds, inability to stand, walk, or sit for sustained periods or perform these activities for over three to four hours in terms of an eight hours workday, inability to operate foot controls or do any climbing or balancing, and severely limited capacity to kneel, stoop, crawl, or crouch (20 CFR 404.1545).
>
> 6. The claimant is unable to perform any of her past relevant works.
>
> 7. The claimant's residual functional capacity for the full range of sedentary work is reduced by limitations shown in item 5.

(*Id.* at 4; *see also id.* at 2-3 (discussing and evaluating evidence presented by Epps-Malloy).)

UNUM requested Dr. Stein to provide further information in October 1994. (Szymanski Certif. Ex. S: Letter from Jodi Silberman to Dr. Randolph Stein dated 10-20-94.) Again, the physician diagnosed Epps-Malloy with fibromyalgia and

chronic pain syndrome. (*Id.* Ex. T: Supplementary Medical Report dated 10-26-94 ("Dr. Stein Supp. Report") at 1.) He noted that she was unable to "perform physical labor for any length of time" (*id.* at 2) and concluded that he did not expect her condition to improve sufficiently in the future (*id.* at 1).

UNUM began to review Epps-Malloy's status in 1996. (Dukes Aff. Ex. N: Letter from Susan Spradlin to Celeslie Epps dated 5-22-96 ("5-22-96 Letter").) UNUM sought current information from Epps-Malloy regarding her education and employment history and her treating physicians. (Dukes Aff. ¶ 18.) Epps-Malloy completed the requested form regarding her education and employment history. (*Id.* Ex. P: Education and Employment History Form.) In May of 1996, UNUM requested information from the two doctors Epps-Malloy referred to as her treating physicians, Dr. Pannullo and Dr. David L. Williams ("Dr. Williams"). (Dukes Aff. ¶ 19.)

Dr. Pannullo informed UNUM that Epps-Malloy had sarcoidosis of the lung but that, as Epps-Malloy's gynecologist, she was not treating her for this condition. (Szymanski Certif. Ex. V: Questionnaire from Susan Spradin to Dr. Pannullo dated 6-12-99 ("First Dr. Pannullo Questionnaire") at 1.) In a second UNUM questionnaire, Dr. Pannullo diagnosed Epps-Malloy with "Postmenopausal Replacement." (*Id.* Ex. X: Questionnaire dated 8-12-96 ("Second Dr. Pannullo Questionnaire").) She reiterated that she was not treating Epps-Malloy for any illness and that Epps-Malloy had a good prognosis for a return to work. (*Id.*)

Dr. Williams's notes, dated January 16, 1996, stated:

> . . . . [Epps-Malloy] has had a total hysterectomy in July of 1995 for a class 3 pap and will need gynecological follow up with a female gynecologist here when she is back in three months. Also, in 1989 she had a diagnosis of sarcoidosis made by broncoscopy and we have records of an FEV1 of 2000. She also has fibromyositis

> and has pain her left hip, back, and knee. She also has had some severe rectal bleeding in the past but has been worked up and called diverticular disease. She is on Premarin 1.25 mg daily. When she has taken steroids in the past, she has had dramatic changes in her mood and became quite cushingoid.

(*Id.* Ex. W: Notes of David L. Williams, M.D., P.A., dated 1-16-96 ("Dr. Williams 1-16-96 Notes").) According to his June 14, 1996 notes:

> Celeslie is in today. We did a complete physical on her today. Her BP is 135/85. HEENT, HEART, LUNGS: within normal limits. OROPHARYNX: benign. NECK: supple. THYROID: not enlarged. CHEST: equal expansion bilaterally. No dullness to percussion. No lag nor rales. HEART: no murmurs, heaves or thrills. BREASTS: no masses. ABDOMEN: liver, kidneys, spleen nonpalpable. PELVIC: performed from a normal appearing vagina. She has had a hysterectomy. RECTAL: no masses. HEMOCCULT: negative stool. EXTREMITIES: no cyanosis, clubbing or edema. Bilateral mammography was ordered. I have identified no new health problems today. We are going to refill all of her medicines. I have put her on Elavil 25 mg at night for fibromyalgia. She is going to bring in her medical records so we can make copies of them. Sarcoidosis is her diagnosis as well as fibromyalgia. Return visit in six months.

(*Id.* Ex. W: Notes of David L. Williams, M.D., P.A., dated 6-14-96 ("Dr. Williams 6-14-96 Notes").)

In a subsequent UNUM questionnaire, Dr. Williams concluded that Epps-Malloy was "disabled to light activity because of shortness of breath" and his prognosis for her to return to gainful full time or part time employment was "never." (*Id.* Ex. Y: Questionnaire dated 10-28-96 ("Dr.

Williams Questionnaire").) He further stated that he had not recently conducted a pulmonary function test on her.[12] (*Id.*) Follow-up visits were scheduled for every six months. (*Id.*)

In a December 31, 1996 letter, UNUM terminated Epps-Malloy's long-term disability benefits.[13] (Dukes Aff. Ex. W: Letter from Gloria J. Dukes to Celeslie Epps-Malloy dated 12-31-96.) The letter explained that, based on the medical documentation received, including information from Drs. Pannullo and Williams, "there is no evidence to support that you are medically incapable to perform the duties of your occupation." (*Id.* at 1.) It further stated that she can seek a review of this determination by the Plan Administrator, but it noted that this request for review must include objective medical evidence. (*Id.*)

With a letter dated January 8, 1997, Epps-Malloy appealed this decision, informing UNUM that she was now under the care of Dr. Fred D. McQueen, Jr. ("Dr. McQueen"). (Epps-Malloy Aff. ¶ 31; Szymanski Certif. Ex. CC: Letter from Celeslie Epps-Malloy dated 1-8-97.) She also submitted a

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[12] Although neither party specifically addresses the question, it appears that a pulmonary function test constitutes one of the tests used to diagnose sarcoidosis. *See, e.g.*, Am. Lung Assoc., *Sarcoidosis*, http://www.lungusa.org/diseases/lungsarcoido.html (last visited 10-15-01) (stating that sarcoidosis is initially suspected based on x-rays, lab tests, and pulmonary function studies); Nat'l Heart Lung, & Blood Inst., *Sarcoidosis*, http://nhlbi.nih.gov/health/public/lung/other/sarcoidosis/index.htm (last visited 10-15-01) (noting that, while no one single test can be relied on to diagnose sarcoidosis, pulmonary function tests often provide clues for diagnosis); Nat'l Jewish Med. & Research Ctr. *Sarcoidosis*, http://www.nationaljewish.org/medfacts/sarcoid.html (last visited 10-15-01) (listing pulmonary function tests among procedures to diagnose sarcoidosis but noting that they do not substitute for more specific tests).

[13] According to Epps-Malloy, she had a telephone conversation with Gloria Dukes, a senior benefits analyst (Dukes Aff. ¶ 1), on or about November 25, 1996 in which she was informed that UNUM had lost many of Epps-Malloy's medical records. (Epps-Malloy Aff. ¶ 28.)

completed medical questionnaire sent to her by UNUM in November 1996. (Epps-Malloy Aff. ¶ 33; Szymanski Certif. Ex. DD: Questionnaire dated 11-25-96.) Following a letter from UNUM dated January 10, 1997 (Szymanski Certif. Ex. DD: Letter from Gloria J. Dukes to Ms. Celeslie Epps-Malloy dated 1-10-97), she sent another letter, dated January 15, 1997, listing her current medications. (*Id.* Ex. FF: Letter from Celeslie Epps-Malloy dated 1-15-97.) At UNUM's request, Dr. McQueen forwarded his notes from a visit with Epps-Malloy on January 7, 1997 and information from her 1995 admission to Hamlet Hospital. (Dukes Aff. ¶ 26.) Dr. McQueen stated:

> I have a letter from Beth McKoy, stating that [Epps-Malloy] has fibromyositis and abnormalities of her blood work. She had GGTP of 521, ALT of 60, SGOT of 51 and alk phos 137, triglycerides of 109. She is advised that I will try to cooperate with her and her attorney. She has severe sarcoidosis. She is permanently & totally disabled by Social Security. She has respiratory distress @ rest and may soon require Home 02. The pt has been on medication: cough syrup with codeine tid and I want her to change to Endal. She is on Beconase AQ nasal inhaler for her sinuses and Darvocet for pain. She has been dx'ed with firbomyositis and she is on hormone therapy, Premarin and PROvential inhaler. I want her on Volmox (samples given). She cannot return to gainful employment. She has skin lesions appearing on her legs from the sarcoid. Placing on steroid cream; Ultravate to use bid. I do not feel it in her best interest to be under any stress due to triggering her sarcoid remission. She has had trigger pt injections in the past. She has muscle spasms due to her disease process. Placing on muscle relaxants and advised heat and no lifting, pulling or pushing. She has problem with severe arthritis. Permanently & totally disabled. Suffers from severe anxiety. She cannot cope with stress.

(Dukes Aff. Ex. BB: Dr. McQueen Notes ("Dr. McQueen Notes").) The discharge summary from Epps-Malloy's Hamlet Hospital admission by Dr. Bharatkumar Thakkar ("Dr. Thakkar") noted that she underwent a hysterectomy and had a past medical history of sarcoidosis as well as rectal bleeding. (*Id.* Ex. BB: Discharge Summary from Hamlet Hospital ("Hamlet Hospital Discharge Summary") at 1.) In additional notes from this admission, Dr. Thakkar stated that Epps-Malloy had a history of sarcoidosis, pancreatitis, and cholelithiasis. (Id. Ex. BB: Hamlet Hospital Medical Record ("Hamlet Hospital Medical Record") at 1.)

According to Epps-Malloy, in a telephone conversation in January 1998, Gloria Dukes ("Dukes"), a senior benefits analyst at UNUM (Dukes Aff. ¶ 1), informed her that she did not "sound sick" and questioned Dr. McQueen's report. (Epps-Malloy Aff. ¶ 38.) In February 1997, Nurse Ann Girardo ("Nurse Girado") examined Epps-Malloy's file for UNUM. (Dukes Aff. ¶ 27.) Commenting on Dr. McQueen's notes, Nurse Girardo wrote in full:

> Dr. Fred McQueen's 1/7/97 note includes subjective complaints re: respiratory distress @ rest, w/o info. re. chest auscultation, spirometry, or saturation on room air. He notes "abnormalities of blood work"-these are not, inherently, preclusive of work capacity. He notes muscle spasms-does not specify location, frequency, duration, intensity.

(*Id.* Ex. CC: Comments of Ann Girado dated 2-3-97 ("Nurse Girado Comments").) With a letter dated February 4, 1997 ("2-4-97 Letter"), UNUM informed Epps-Malloy that the additional information furnished by her was "not sufficient to reverse [its] previous decision." (*Id.* Ex. DD: Letter from Gloria J. Dukes to Ms. Celeslie Epps-Malloy dated 2-4-97 ("2-4-97 Letter").) The materials were therefore submitted to UNUM's Quality Review Section for "an impartial review as provided under ERISA." (*Id.*)

In connection with this impartial review, UNUM requested, at Merck's direction, that Epps-Malloy appear for a May 1997 independent examination by Dr. Gautam Dev ("Dr. Dev"), a pulmonology specialist with Fayetteville Pulmonology. (Dukes Aff. ¶¶ 28-29 & Letter from Gloria J. Dukes to Ms. Celeslie Epps-Malloy dated 2-5-97.) After examining Epps-Malloy, Dr. Dev stated in full:

> I saw Celeslie Epps-Malloy on 5/8/97. The patient is a 47 year old female with a history of sarcoidosis reportedly diagnosed by a transbronchial biopsy in 1987. The patient currently presents for medical evaluation for her complaints of shortness of breath on minimal exertion and also complains of cough, which is non-productive and is worse upon laying down. The patient also has post-nasal drip and chronic sinus problems. Her exercise tolerance is minimal and she is barely able to achieve her day-to-day activities. The patient was treated in the past with steroids; however, could not tolerate them because of what appears to be psychosis and marked degree of weight gain. She has a history of smoking one pack per day for six years. Her physical exam showed stable vitals and no adenopathy in the head and neck area. No jugular venous problems. Her chest was clear to ausculation and cardiac exam showed a normal S-1, S-2 without any murmur or gallop. Her abdomen was soft and non-tender. No hepatosplemogaly felt. Bowel sounds were active. Extremities did not show any edema or rash. Her joints did not reveal any tenderness or limitation of motion. Neurologically, the patient was alert and oriented without any focal motor sensory deficit. Her musculoskeletal exam was unremarkable.
>
> Her pulmonary function tests were within normal limits. Her arterial blood gas at rest on room air showed a pH of 7.40, p002 32.8, p02 of 86.

> My impression of Mrs. Epps-Malloy is that her symptomatology is not commensurate with her clinical presentation. Considering the normal pulmonary function test and near normal arterial blood gas, I have a difficult time ascribing sarcoidosis as a cause of her symptomatology. She appears to be somewhat emotional and I cannot reliably exclude her malingering behavior. On the contrary, the endobronchial sarcoid may be leading to persistent cough and dyspnea. Chronic sinusitis can also exacerbate a respiratory condition and lead to some degree of shortness of breath. The patient's impaired cardiac status is also a possibility and an exercise stress test might be able to help answer some of the unanswered questions.
>
> I feel, based on her pulmonary function tests and arterial blood gas information, that her present diagnosis is incompatible with her clinical presentation.

(Szymanski Certif. Ex. NN: Letter from Gautum Dev, M.D., dated 5-19-97 ("Dr. Dev Report").)

Based on Dr. Dev's examination and other documentation in her record, UNUM upheld its decision to terminate Epps-Malloy's benefits. (Dukes Aff. ¶ 30.) UNUM informed her by letter, dated June 4, 1997, as follows:

> We have received the report from Gautam Dev, MD. The report dated 5/18/97 indicates Dr. Dev performed a Pulmonary Functions test and a arterial study (blood gas). The results of these exams were normal. Therefore, your claim will remain terminated.

(Szymanski Certif. Ex. 00: Letter from Gloria J. Dukes to Celeslie Epps-Malloy dated 6-4-97 ("6-4-97 Denial Letter").)

Epps-Malloy asserts that she was and continues to be completely disabled (Epps-Malloy Aff. ¶ 52), and she instituted suit in this Court to recover benefits she claims she was entitled to under the Plan. In an Amended Complaint,

Epps-Malloy and another plaintiff, Michaleen Kosiba ("Kosiba"),[14] allege a breach of fiduciary duty under ERISA by refusing to pay long-term disability benefits and terminating disability benefits previously paid. (Am. Compl. First Cause of Action, Second Cause of Action.) On June 21, 1999, the Court granted the motion of Merck and UNUM to dismiss on the grounds that ERISA does not provide a private cause of action for a breach of fiduciary duty in this context. (Mem. & Order filed 6-21-99 at 2-5.) The Court, however, permitted plaintiffs to file a Second Amended Complaint asserting a claim for benefits under 29 § 1132(a)(1)(B) against all three defendants. (*Id.* at 5-11.)

In this Second Amended Complaint, Epps-Malloy asserts four causes of action. All causes of action are based on alleged violations of 29 U.S.C. § 1132(a)(1)(B). In the First Cause of Action, she alleges that Merck and UNUM, by refusing to pay long-term benefits, have unlawfully denied benefits owed under the Plan. (Second Am. Compl. ¶ 27.) She alleges in her next cause of action that Merck and UNUM have unlawfully terminated these benefits through their arbitrary, capricious, and inconsistent administration of the Plan. (*Id.* ¶ 30.) The Third Cause of Action alleges that the Merck Plan has unlawfully denied benefits to which Epps-Malloy is legally entitled. (*Id.* ¶ 33.) Her final cause of action alleges that defendants have unlawfully denied benefits to Epps-Malloy by arbitrarily and capriciously offsetting the receipt of these benefits. (*Id.* ¶ 46.) Epps-Malloy seeks: (1) a declaratory judgment to the effect that she is disabled under the Plan; (2) a monetary judgment of the amount owed under the Plan; (3) a permanent injunction restraining defendants from denying disability benefits as long as her condition remains unchanged; (4) attorney's fees and costs; and (5) other just and equitable relief, including prejudgment interest.

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[14] An order was filed on March 16, 2000 dismissing this action as to Kosiba without prejudice. (Order filed 3-16-00.)

(*Id.* at 10.) Defendants filed their Answer to this Second Amended Complaint on October 15, 1999. This Answer includes a counterclaim against Epps-Malloy for an overpayment of benefits to Epps-Malloy allegedly arising out of the failure to offset or reduce such payments to reflect Social Security disability payments. (Answer Counterclaim ¶¶ 1-4.)

Defendants moved for summary judgment on April 24, 2000. In the 7-17-00 Memorandum and Order, the Court granted this motion in part and denied it in part. We granted it as to defendants' right to restitution of any overpayments. (7-17-00 Mem. & Order at 20.) We denied this motion as to the amount of any such overpayments. (*Id.*) Most importantly, this Court denied the motion as to the termination of Epps-Malloy's long-term disability benefits because of the presence of genuine issues of material fact regarding whether UNUM acted in an arbitrary and capricious fashion when it terminated these benefits. (*Id.* at 16, 20.) The Court subsequently then directed the parties to submit briefs in lieu of a formal bench trial. The Court also bifurcated the trial of this matter. Under this bifurcation, the determination of the amount of any offset possibly owed by Epps-Malloy under defendants' counterclaim will be determined at a future date. Currently before the Court is the issue of the potential liability of defendants for the termination of benefits. Therefore, the Court must consider the First, Second, and Third Causes of Action in Epps-Malloy's Second Amended Complaint.

DISCUSSION

This matter is before the Court for judgment pursuant to Rule 52(a),[15] permitting the Court to adjudicate, with the

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[15] Rule 52(a) states:

> In all actions tried upon the facts without a jury or with an advisory jury, the court shall find the facts specially and state separately its

consent of the parties, a case based on the summary judgment record without a formal trial. *Nat'l Res. Def. Council, Inc. v. Fox*, 93 F. Supp. 2d 531, 535 (S.D.N.Y. 2000) (quoting *Acuff Rose Music, Inc. v. Jostens, Inc.*, 155 F.3d 140, 142 (2d Cir. 1998)), *aff'd in part & remanded in part sub nom., Natural Res. Def. Council, Inc. v. Maszynski*, 208 F.3d 91 (2d Cir. 2001). The factual record in this matter comes from the summary judgment motion of defendants granted in part and denied in part by the Court in its 7-17-00 Memorandum and Order.

While the Court will refer to our previous consideration of factual matters in the 7-17-00 Memorandum and Order, we are not bound by any previous factual observations. Epps-Malloy relies rather extensively on the 7-17-00 Memorandum and Order and argues that judgment should be entered in her favor regarding her entitlement to benefits based on the Court's alleged rejection of defendants' summary judgment arguments. (Civil Action - Trial Br. of Pl. Celeslie Epps-Malloy ("Pl.'s Br.") at 2, 24-26.) Our primary concern in the 7-17-00 Memorandum and Order was whether genuine issues of material fact prevented summary judgment for defendants.

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conclusions of law thereon, and judgment shall be entered pursuant to Rule 58; and in granting or refusing interlocutory injunctions the court shall similarly set forth the findings of fact and conclusions of law which constitute the grounds of its action. Requests for findings are not necessary for purposes of review. Findings of fact, whether based on oral or documentary evidence, shall not be set aside unless clearly erroneous, and due regard shall be given to the opportunity of the trial court to judge of the credibility of the witnesses. The findings of a master, to the extent that the court adopts them, shall be considered as the findings of the court. It will be sufficient if the findings of fact and conclusions of law are stated orally and recorded in open court following the close of the evidence or appear in an opinion or memorandum of decision filed by the court. Findings of fact and conclusions of law are unnecessary on decisions of motions under Rule 12 or 56 or any other motion except as provided in subdivision (c) of this rule.

The Court, however, must now make full findings of fact, as well as conclusions of law, with respect to the ultimate merits of Epps-Malloy's claims at issue. Specifically, Epps-Malloy is no longer entitled to having all reasonable inferences drawn in her favor. *Natural Res. Def. Council*, 93 F. Supp. 2d at 535 (stating that, in deciding motions for final judgment, neither side has benefit of having all reasonable inferences made in its favor).

I. Standard of Review

Epps-Malloy seeks relief under 29 U.S.C. § 1132(g)(1)(B), which authorizes a beneficiary or participant to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." In considering whether a plan participant ought to prevail under this provision when the plan administrator has denied or terminated benefits, a court must review such a denial or termination under an "arbitrary and capricious" standard when the plan confers discretionary authority upon the administrator. *See, e.g., Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) ("[A] denial of benefits challenged under § 1132(a)(1)(B) [of ERISA] is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."); *Abnathya v. Hoffman-La Roche, Inc.*, 2 F.3d 40, 45 (3d Cir. 1993) (stating that application of deferential arbitrary and capricious standard is appropriate where benefits plan gives administrator discretionary authority to determine eligibility). The Court will continue to apply this deferential standard to UNUM's termination of Epps-Malloy's long-term disability benefits.

This Court earlier concluded that the arbitrary and capricious standard governs our review in this context. In its 7-17-00 Memorandum and Order, the Court held that "[t]he

arbitrary and capricious standard of review will continue to apply where: (1) the ERISA plan gives the administrator the discretionary authority to determine eligibility for benefits, and (2) the plan administrator designates another fiduciary to determine claims, as specifically provided for in the plan." (7-17-00 Mem. & Order at 12-13 (citing *Madden v. ITT Long Term Disability Plan For Salaried Employees*, 914 F.2d 1279, 1284 (9th Cir. 1990); *Risenhoover v. Bayer Corp. Group Health Plan*, 83 F. Supp. 2d 408, 411 (S.D.N.Y. 2000)). The Court determined that the arbitrary and capricious standard applies because the Plan satisfies these two requirements. (*Id.* at 13 (citation omitted).)

Epps-Malloy apparently accepts the application of this arbitrary and capricious standard to this matter, arguing that the decision to terminate her benefits was arbitrary and capricious. (Pl.'s Br. at 17-18.) She, however, also seeks the application of a heightened arbitrary and capricious standard based on the "intervening decision" in *Pinto v. Reliance Standard Life Insurance Co.*, 214 F.3d 377 (3d Cir. 2000). (*Id.* at 33.) According to Epps-Malloy, such a modified standard applies because of the inherent conflict of interest created by Merck serving as both the Plan Administrator and the source of the Plan's funds. (*Id.*) Defendants respond to this argument by asserting that the *Pinto* court found that a heightened standard of review does not apply to such a self-funded plan in which the employer makes claim determinations. (Defs.' Br. at 21 n.3.)

Neither Epps-Malloy nor defendants fully address the difficult question raised by the *Pinto* case. The *Pinto* court itself concluded that, even absent specific evidence of partiality or bias, a heightened arbitrary and capricious standard ordinarily applies when an insurer is responsible for both funding and administering benefits. *Pinto*, 214 F.3d at 378. This heightened standard arises out of a structural conflict of

interest inherent in the manner in which the plan is funded and administered. *Id.*

The *Pinto* heightened standard review potentially could apply to arrangements outside of the insurance company context. The Third Circuit stated that arrangements ordinarily not presenting an inherent conflict of interest could mandate higher scrutiny based on certain variations altering the incentives of the administrator. *Id.* at 383 & n.3. Third Circuit decisions have used language, admittedly often in dicta, showing that *Pinto's* heightened standard of review could apply outside of the specific context of insurance. See *Skretvedt v. E.I. DuPont De Nemours & Co.*, 268 F.3d 167, 174-75 (3d Cir. 2001); *Goldstein v. Johnson & Johnson*, 251 F.3d 433, 442 (3d Cir. 2001); *Orvosh v. Program of Group Ins. for Salaried Employees of Volkswagen of Am.*, 222 F.3d 123, 129 n.1 (3d Cir. 2001). For instance, the Third Circuit in *Orvosh v. Program of Group Insurance for Salaried Employees of Volkswagen of America* applied the ordinary arbitrary and capricious standard to a case in which the employer was the official plan administrator but UNUM carried out important administrative functions as well. 222 F.3d at 129 n.7. The court did so, however, on the basis of party stipulations, and it further stated that "[a]fter this case was argued, we decided that a heightened standard of review applies where the same entity both funds and administers an ERISA plan." *Id.* (citing *Pinto*, 214 F.3d at 377). At least two district court decisions from this circuit have concluded that the *Pinto* approach is not limited to the insurance context and could apply to an employer who funds and administers a plan. *Rendulic v. Kaiser Aluminum & Chem. Corp.*, 166 F. Supp. 2d 326, 333-37 (W.D. Pa. 2001); *Frieberg v. First Union Bank of Del.*, No. Civ.A. 99-571-JJF, 2001 WL 826549, at *2-*5 (D. Del. July 18, 2001).

The Court must still determine when this less deferential standard actually applies outside of the specific context add-

ressed in *Pinto*. As recognized not only by *Pinto* but by prior case law, an employer who funds and administers an ERISA plan is not automatically subject to heightened scrutiny on the grounds of an inherent conflict of interest. *See, e.g.*, *Pinto*, 214 F.3d at 383-90; *Abnathya*, 2 F.3d at 45 n.5. But such a deferential attitude is premised on the incentives of the administrator indicating that an inherent conflict of interest does not exist for purposes of the ERISA standard of review. If the plan's characteristics and incentives are sufficiently akin to the arrangement at issue in *Pinto* to demonstrate such a inherent conflict of interest, then heightened scrutiny is appropriate. *See Rendulic*, 166 F. Supp. 2d at 333-371; *Frieberg*, 2001 WL 826549, at *2-*5.

In assessing whether such a similarity with the *Pinto* arrangement exists, a court should consider several important factors identified by courts of this circuit. The plan's method of funding constitutes possibly the most important factor. *Rendulic*, 166 F. Supp. 2d at 335-36; *Frieberg*, 2001 WL 826549, at *4. According to the Third Circuit in *Skretvedt v. E.I. DuPont De Nemours & Co.*, 268 F.3d 167 (3d Cir. 2001), *Pinto* held that a heightened standard of scrutiny is appropriate "when a pension plan is unfunded, i.e., not 'actuarially grounded, with the company making fixed contributions to the pension plan,' but rather funded by the employer on a claim-by-claim basis," *id.* at *5 (citation omitted).[16] If the employer makes fixed contributions to a trust fund, it "'incurs no direct expense as a result of the allowance of benefits, nor does it benefit directly from the denial or discontinuation of benefits.'" *Pinto*, 214 F.3d at 388 (citations omitted); *see also Rendulic*, 166 F. Supp. 2d at 335-36; *Frieberg*, 2001 WL

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[16] The *Skretvedt* court, although it noted that portion of the benefits were unfunded because the employer failed to make actuarially determined payments, refrained from specifically deciding whether a heightened standard applied because the decision failed the arbitrary and capricious test. 268 F.3d at 174-75.

826549, at *4; *Krause v. Modern Group, Ltd.*, 156 F. Supp. 2d 437, 444 (E.D. Pa. 2000) (citation omitted). However, if the benefits come directly out of the employer's operating funds, the employer, like an insurer funding and administering a plan, possesses a financial incentive to deny claims because any payment constitutes a direct expense to the employer. *See, e.g., Rendulic*, 166 F. Supp. 2d at 335-36; *Frieberq*, 2001 WL 826549, at *4; *see also Pinto*, 214 F.3d at 389 ("For example, we noted that the defendants in those cases did not 'incur' a 'direct expense as a result of the allowance of benefits,' or 'benefit directly from the denial or discontinuation of benefits,' implying that a company that did profit directly would be subject to a more stringent standard." (citations omitted)). Therefore, courts have applied a heightened arbitrary and capricious standard based, at least in part, on the employer's decision to run the plan from its operating funds. *Rendulic*, 166 F. Supp. 2d at 335-36; *Frieberg*, 2001 WL 826549, at *4; *see also Goldstein*, 251 F.3d at 442 (stating that, if plan in question were not top hat plan, the fact that its funds come directly from the operating revenues of employer and administrator would have been considered in determining standard of review).

The desire to maintain employee morale and low salaries also plays a role in this analysis. The incentive to grant benefits in order to maintain morale and avoid demands for higher wages generally makes it less likely that an inherent conflict of interest requiring heightened scrutiny exists. *See, e.g., Pinto*, 214 F.3d at 389 (citation omitted); *Frieberg*, 2001 WL 826549, at *4. The existence of this incentive assumes a certain stability on the part of the employer, and its weight is significantly reduced when "companies are breaking up, or laying off a significant percentage of their employees, or moving all their operations." *Pinto*, 214 F.3d at 392 (citation omitted); *see also Rendulic*, 166 F. Supp. 2d at 335 (citation omitted); *Frieberg*, 2001 WL 826549, at *4. Similarly, the claimant's status as a former employee indicates that this

incentive applies with much less force. *Rendulic*, 166 F. Supp. 2d at 335 (citation omitted); *Frieberg*, 2001 WL 826549, at *4.

An employer also could have more of an incentive to deny valid benefits, thus requiring a higher standard, when it faces numerous claimants or is concerned about establishing a precedent for future claims than when it confronts individual discrete claimants. *Rendulic*, 166 F. Supp. 2d at 336 (citation omitted); *Frieberg*, 2001 WL 826549, at *4; *see also, e.g., Pinto*, 214 F.3d at 386 (citing *Nazay v. Miller*, 949 F.2d 1323, 1335 (3d Cir. 1991)). Under such circumstances, a heightened standard of review could be appropriate.

Turning to the structural arrangement involved in this case, the Court concludes that it should refrain from applying any heightened standard of review. Such a result is based not merely on our previous application of the non-heightened arbitrary and capricious standard to defendants' summary judgment motion (7-17-00 Mem. & Order at 11-13) or the fact that Epps-Malloy as well as defendants generally limit their arguments to the proper application of this unmodified standard (Pl.'s Br. at 17-32; Defs' Br. at 21-36). The Court reaches this conclusion because it cannot say that the structural details at issue implicate an inherent conflict of interest calling for such a higher standard of review. Admittedly, while UNUM serves as Claims Administrator (Plan; Dukes Aff. ¶ 2), Merck acts as the overall Plan Administrator (Plan). *See Orvosh*, 222 F.3d at 129 n.7 (noting existence of apparently similar arrangement where UNUM performed administrative functions but employer served as formal plan administrator). No party, however, specifically addresses the factors discussed above. For instance, the Court notes that the Plan provides for alternative methods of funding, ranging from the establishment of an ERISA trust

fund to the direct payment of benefits out of Merck's operating funds.[17] The Court has not been provided with

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[17] Although not addressed by the parties, certain Plan provisions do deal with the methods of funding. Section 5.2 provides:

> The Management Pension Investment Committee shall be responsible for establishing a funding policy and method consistent with the objectives of the Plan and the requirements of ERISA. The Management Pension Investment Committee may, in its discretion, from time to time, select any funding method, or combination of funding methods which are permissible under ERISA. Such funding methods may include, in any combination selected by the Management Pension Investment Committee:
>
> (i) the payment of benefits out of the general assets of the Employer;
>
> (ii) the purchase of benefits by the Employer through insurance; or
>
> (iii) the provision of benefits through one or more trusts, as described in Section 5.3, or other funding media permissible under §403(b) of ERISA. A change in the method of funding the Plan, or Funding Medium shall not constitute an amendment of the Plan.

Section 5.4 provides for the method of contributions:

> Nothing contained in this Plan shall be construed to require the Management Pension Investment Committee to establish a Funding Medium to provide Plan benefits, or to require the Employer to make contributions to a Funding Medium which is established. However, the Employer may, in its discretion, make contributions to a Funding Medium on an annual basis in such amounts as it, in consultation with the actuary appointed by the Plan Administrator, deems appropriate.
>
> If a Funding Medium is established, the benefit payments may be made directly from the Funding Medium, or directly by the Em ployer. If benefits are paid directly by the Employer, its contributions to the Funding Medium shall be reduced accordingly.

According to the claim administration agreement entered between Merck and UNUM's predecessor, Merck "funds the Plans through the Employee Benefits Trust (hereinafter referred to as the 'Trust') and has entered into a trust agreement with Bankers Trust Company as Trustee of the Trust (hereinafter referred to as the 'Trustee')." (*Id.*) The Plan further provides:

specific information regarding the actual funding of the Plan by Merck. No evidence that Merck is undergoing reorganization or that this case involves more than the disability benefits claim of a single individual. The application of a heightened arbitrary and capricious standard of review is not required in this case.[18]

Under the arbitrary and capricious standard of review, a "district court may overturn a decision of the Plan administra-

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> At no time and under no circumstances may any funds which have been contributed to any Trust or other Funding Medium which is a part of this Plan, or any income therefrom, be used for or diverted to purposes other than the exclusive benefit of the Participants, including defraying reasonable expenses of administering the Plan.

(*Id.*)

[18] The Court notes that the judicial application of the *Pinto* approach has not always been consistent. For instance, in *Ayers v. Maple Press Co.*, 168 F. Supp. 2d 349 (M.D. Pa. 2001), the district court applied a heightened standard when the claimant's employer served as both plan administrator and funder of the plan, before considering such factors as the manner of funding, *id.* at 353-54. We believe, however, that consistent with *Pinto*, a heightened standard is not automatically implicated when an employer both administers and funds an ERISA plan, requiring instead a full consideration of factors.

Even following the *Ayers* approach, the proper standard would not be altered significantly. *Pinto's* heightened standard apparently implicates a sliding scale of deference, with the final standard adopted based on the apparent conflicts present in the case. *Pinto*, 214 F.3d at 390-95. The *Ayers* court, given the general interest in employee morale as well as the absence of evidence showing the method of funding, applied "a standard that is heightened, but very close to arbitrary and capricious." *Ayers*, 168 F. Supp. 2d at 354. Epps-Malloy, while arguing that *Pinto's* "modified, sliding scale arbitrary and capricious standard" ought to apply, never specifies her desired location along this scale. (Pl.'s Br. at 33.) Due to this absence as well as the uncertainty regarding the funding mechanism and the employer's preferences and incentives, any standard to be applied, even a heightened one, would be practically indistinguishable from the traditional arbitrary and capricious standard previously applied by the Court.

tor only if it is 'without reason, unsupported by substantial evidence or erroneous as a matter of law.'" *Abnathya*, 2 F.3d at 45 (citation omitted). Under this "extremely deferential" standard of review, *see, e.g., Frieberg*, 2001 WL 826549, at *1 (citing *Pinto*, 214 F.3d at 393), "'the court is not free to substitute its own judgment for that of the defendants in determining eligibility for the plan benefits.'" *Abnathya*, 2 F.3d at 45 (citation omitted).

II. Termination of Benefits

Epps-Malloy contends that UNUM's decision[19] to discontinue her long-term disability benefits was not supported by substantial evidence and fails to satisfy the arbitrary and capricious standard. (Pl.'s Br. at 18.) The Court finds that UNUM's determination was not arbitrary and capricious in that it: (1) was reasonable, (2) is supported by substantial evidence in the administrative record, and (3) is not erroneous as a matter of law. *See, e.g., Abnathya*, 2 F.3d at 45 (quotation omitted). The Court reaches this finding on the basis of the documentation before UNUM at the time it made its determination finally terminating her benefits as well as general medical background information.[20]

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[19] The Court will refer to UNUM as the decision-maker regarding the termination of Epps-Malloy's benefits. Although Epps-Malloy asserts that the Merck played an active role in this determination (Pl.'s Br. at 32-33), the Court wi follow its 7-17-00 Memorandum and Order in referring to UNUM alor for purposes of our discussion. (*See* 7-17-00 Mem. & Order at 8.) As explained in our conclusion, the Court need not reach the second question of Merck's potential liability in this matter.

[20] It is well-established that a court is limited to "that evidence that was before the administrator when it made the decision being reviewed." *Mitchell v. Eastman Kodak Co.*, 113 F.3d 433, 440 (3d Cir. 1997); *see also, e.g., O'Sullivan v. Metro. Life Ins. Co.*, 114 F. Supp. 2d 303, 309 (D.N.J. 2000) (citations omitted). A court, however, may consider other evidence related to either plan interpretation or the explanation of medical terms and procedures. *See, e.g., O'Sullivan*, 114 F. Supp. 2d at 310

Epps-Malloy's case for arbitrary and capricious conduct essentially depends on two prongs: (1) the medical reports submitted by various physicians since 1992, as well as the Social Security Decision, allegedly demonstrating her total disability under the Plan; and (2) the alleged deficiencies in the medical evidence specifically relied upon by UNUM in terminating her benefits. (Pl.'s Br. at 18-32; P1. Epps-Malloy's Reply Br. ("Pl.'s Reply Br.") at 1-5.) The Court therefore must examine this evidence in order to determine whether the termination decision was "without reason, unsupported by substantial evidence or erroneous as a matter of law." *Abnathya*, 2 F.3d at 45 (quotation omitted).

The Court will begin its analysis with the more recent reports submitted by Epps-Malloy as well as the evaluations of Dr. Dev and Nurse Girado specifically relied upon by UNUM in its determination. A consideration of these more contemporary and therefore more relevant matters, commencing with Dr. Dev's report, provides the appropriate

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(citing *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 310 (5th Cir. 1999)). This evidence, while not acceptable to resolve disputed material facts, may be used to "assist[ ] the district court in understanding the medical terminology or practice relating to a claim." *Id.* (quoting *Vega*, 188 F.3d at 299).

Following the example of this Court's 7-17-00 Memorandum and Order (7-17-00 Mem. & Order at 3 n.5, 4 n.6), defendants refer to medical information available from Internet sources (Def.'s Br. at 8-10, 25). Epps-Malloy contends it is improper for defendants to advance arguments based on such sources because they represent new medical arguments beyond the scope of the administrative record. (P1. Epps-Malloy's Reply Br. at 3.) Epps-Malloy, however, apparently admits that such materials may be used as "helpful background information." *(Id.* at 2.) The Court will therefore consider this information insofar as it assists our basic understanding of medical terms and procedures. But such information will not be considered to resolve any disputes of material fact. Otherwise, the Court will limit its review to the materials in the administrative record before UNUM when it terminated Epps-Malloy's benefits.

context for an evaluation of the earlier materials as well as the Social Security Decision.

The more recent documents were submitted in connection with the administrative process begun in 1996 that ultimately led to the termination of Epps-Malloy's benefits under the Plan. (5-22-96 Letter.) In connection with this review process, information and reports were submitted by Epps-Malloy's treating physicians, Drs. Pannullo, Williams, and McQueen. (*See* First Dr. Pannullo Questionnaire; Second Dr. Pannullo Questionnaire; Dr. Will'ams 1-16-96 Notes; Dr. Williams 6-14-96 Notes; Dr. Williams Questionnaire; Dr. McQueen Notes.) UNUM also had before it the reports of Dr. Dev and Nurse Girado. (See Dr. Dev Report; Nurse Girado Comments.) Even after fully considering such evidence, the Court finds that UNUM's termination did not constitute an arbitrary and capricious action.

As pointed out by both this Court and Epps-Malloy (7-17-00 Mem. & Order at 15; Pl.'s Br. at 24-28; Pl.'s Reply Br. at 3-4), Dr. Dev's report does contain certain apparent deficiencies detracting from its weight in our determination of whether UNUM acted in an arbitrary and capricious fashion. Perhaps most importantly, Dr. Dev never expressly stated that Epps-Malloy did not suffer from sarcoidosis or that she was not totally disabled. He also did not address the previous diagnosis of fibromyalgia or any other condition. He stated that "[Epps-Malloy's] endobronchial sarcoid may be leading to persistent cough and dyspnea." (Dr. Dev Report.) Dr. Dev noted certain physical problems and observed that "[t]he patient's impaired cardiac status is also a possibility and an exercise stress test might be able to help answer some of the unanswered questions." (*Id.*) This exercise stress test was never performed. Dr. Dev also never performed a broncho

scopy to confirm or rule out sarcoidosis.[21] Given these apparent deficiencies, Epps-Malloy contends that Dr. Dev never refuted the allegedly substantial and unequivocal evidence of her total disability under the Plan. (Pl's Br. at 23-28; Pl.'s Reply Br. at 3-4.)

But, even taking these countervailing considerations into account, we agree with defendants that the report of Dr. Dev still provides substantial evidence in support of UNUM's determination. Dr. Dev is a specialist in the field of pulmonology. (7-17-01 Mem. & Order at 7-8.) Based on a normal pulmonary function test and nearly normal arterial blood gas results, he found it difficult to consider sarcoidosis as a cause of her symptoms and concluded that "[Epps-Malloy's] present diagnosis is incompatible with her clinical presentation." (*Id.*) Her further found that her joints showed no tenderness or limitation of motion, and the result of the musculo-skeletal examination was "unremarkable." (*Id.*) In fact, Dr. Dev called into question any finding of disability by stating that he could not rule out the possibility of malingering. (*Id.*)

In addition to pointing out the deficiencies in Dr. Dev's report, Epps-Malloy further contends that it ought to be given less weight than the opinions of her treating physicians. (Pl.'s Br. at 27-28.) Defendants apparently respond that the opinion of a treating doctor is entitled to no particular weight and may even be less persuasive because such a doctor would possess a financial incentive to obtain benefits for his or her patients. (Defs.' Br. at 27-28.)

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[21] It appears that a bronchoscopy is another test used in the diagnosis of sarcoidosis. *See, e.g.*, Nat'l Heart, Lung, & Blood Inst., *Sarcoidosis*, http://nhlbi.nih.gov/public/lung/other/sarcoidosis/index.htm (last visited 10-15-01); Nat'l Jewish Med. & Research Ctr., *Sarcoidosis*, http://www.nationaljewish.org/medfacts/sarcoid.html (last visited 10-15-01) (listing pulmonary function tests among procedures to diagnose sarcoidosis but noting that they do not substitute for more specific tests).

While the observations and reports of a treating physician are entitled to greater weight in a Court's analysis in certain circumstances, any additional weight is minimal given the nature of the relationships between Epps-Malloy and her various treating physicians. Despite some case law according no special status to treating physicians, *see, e.g., Dowden v. Blue Cross & Blue Shield of Tex., Inc.*, 126 F.3d 641, 644 (5th Cir. 1997) (per curiam); *Jett v. Blue Cross & Blue Shield of Ala., Inc.*, 890 F.2d 1137, 1140 (11th Cir. 1989); *Harrison v. Aetna Life Ins. Co.*, 925 F. Supp. 744, 748 (M.D. Fla. 1996) (Glazebrook, U.S.M.J.) (citation omitted), the opinion of a treating physician is generally entitled to more weight, at least when this physician has a long-term relationship with the benefits claimant. The Third Circuit in *Skretvedt* recently gave great weight to the opinions of two treating doctors who had "long-term treatment relationships with [the claimant]." *Skretvedt*, 268 F.3d at 184. The circuit court noted that, in the analogous social security disability context, "the 'opinions of a claimant's treating physician[s] are entitled to substantial and at times even controlling weight.'" *Id.* (quoting *Faranoli v. Massanari*, 247 F.3d 34, 43 (3d Cir. 2001)); *see also, e.g., Marchetti v. Sun Life Assurance Co. of Can.*, 30 F. Supp. 2d 1001, 1009 (M.D. Tenn. 1998) (citation omitted). Such an approach is supported by the likelihood that a treating physician has more intimate knowledge of a patient's condition and prognosis than an examining doctor who may only see the person on a single occasion. As the *Skretvedt* court suggested without specifically stating, 208 F.3d at 184, such deference is therefore dependent on the existence of such a long-term relationship between the doctor and the patient, *see, e.g., Pinto*, 214 F.3d at 393 (discussing relationships). It makes little sense to accord such weight to a treating physician who only saw the individual on one or two occasions.

Epps-Malloy does not discuss the nature of her relationships with the doctors she has seen. For instance, her most recent treating physician apparently only examined Epps-

Malloy on one occasion. (*See, e.g.*, Dr. McQueen Notes), and Epps-Malloy stated that she was seen by Dr. Williams twice (Szymanski Certif. Ex. FF: Letter from Celeslie Epps-Malloy dated 1-15-97 ("On the two occasion[s] I was seen by Dr. William[s], I decided that the services I received from him were inadequate for my condition.").) Given that Dr. Dev conducted an in-person examination of Epps-Malloy, his report should be given no less weight than the reports of these treating physicians who only saw her on very few occasions.[22]

While defendants challenge the persuasiveness of the recent reports submitted by Epps-Malloy (Defs.' Br. at 24-32; Defs.' Sur-reply Letter Br. at 2-3), Epps-Malloy asserts that,

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[22] In her reply brief, Epps-Malloy raises a new argument regarding Dr. Dev's report. She contends that this report is inherently unreliable because "it does not appear that [Dr. Dev] was provided with the reports from Epps-Malloy's current and previous treating physicians at the time he conducted his examination." (Pl.'s Reply Br. at 4 (discussing *Hung v. Guardian Life Ins. Co. of Am.*, 229 F.3d 1142 (Table), No. 99-2117, 2000 WL 1099401 (4th Cir. Aug. 7, 2000).) Epps-Malloy, however, does not raise this specific argument until her reply brief, and she cites no evidence in support of her contention. Defendants, in a sur-reply letter brief submitted pursuant to our direction, indicate that UNUM did provide Dr. Dev with Epps-Malloy's medical records. (Def.'s Sur-reply. Letter Br. at 1-2 & Ex. KK: Letter from Jan Isenberg to Gautum Dev, MD dated 3-31-97.) The Court therefore will reject this last-minute argument of Epps-Malloy.

Although not expressly raised by the parties, another possible objection to Dr. Dev's report is the issue of independence and bias. In *Marchetti v. Sun Life Assurance Company of Canada*, 30 F. Supp. 2d 1001 (M.D. Tenn. 1998), the district court called into question the independence of a supposedly impartial medical examiner because of the absence of any proof in the record of independence between the claims administrator and the examiner's company known as "New England Independent Medical Exams, Inc," *id.* at 1009. Given the relative lack of a discussion of any conflict of interest on the part of Dr. Dev, the Court will not question his independence.

even if Dr. Dev's report provided support for the conclusion that she was not totally disabled, "the evidence of her disability was so overwhelming" to make the termination of her benefits arbitrary and capricious. (Pl.'s Br. at 28.) We find that the support Dr. Dev's report provided to UNUM's determination is actually bolstered when the report is compared with the submissions from Drs. McQueen and Williams. These recent submissions simply do not show that UNUM's determination was unreasonable, lacking in substantial evidence, or erroneous as a matter of law.

Dr. McQueen was apparently Epps-Malloy's treating physician at the time UNUM finally terminated her benefits. Admittedly, Dr. McQueen, following a physical examination, diagnosed Epps-Malloy with "severe sarcoidosis" and concluded that she was permanently and totally disabled. (Dr. McQueen Notes.) Dr. McQueen's notes, however, contain certain deficiencies detracting from their weight. In particular, Dr. McQueen apparently did not perform a pulmonary function test, which was performed by Dr. Dev. (Dr. Dev. Report.) While Nurse Giardo's review may be entitled to little weight because she is a non-physician who never actually saw Epps-Malloy, *see, e.g., Donaho v. FMC Corp.*, 74 F.3d 894, 901 (8th Cir. 1996), her observations still call into question Dr. McQueen's conclusions. Although she did not specifically conclude that Dr. McQueen's diagnosis was erroneous (7-17-00 Mem. & Order at 15), Nurse Girado did state that the physician's report referred to subjective complaints without any information regarding chest auscultation, spirometry or saturation on room air, as well as the location, frequency, duration, or intensity of the noted muscle spasms. (Nurse Girado Comments.) Such absences contrast with the more detailed report of Dr. Dev in which he noted that Epps-Malloy's chest "was clear to auscultation" and his examination of her musculo-skeletal system revealed nothing remarkable. (Dr. Dev Report.) Furthermore, Nurse Girado noted that the blood abnormalities observed by Dr. McQueen

were "not, inherently, preclusive of work capacity." (*Id.*) Dr. McQueen's notes, therefore, do not provide significant support for any finding of total disability and therefore do not show that the termination of Epps-Malloy's benefits was unreasonable, without substantial evidence, or erroneous as a matter of law.

UNUM's initial denial letter stated:

> We received another documentation from Dr. Williams dated 10/28/96. This document states that you can perform light duty and he is seeing you every 6 months. Medications are Beconase AQ Nasal spray, Beconase AQ Inhaler, Premarin and Elavil at bedtime.

(12-31-96 Termination Letter at 1.) Dr. Williams did clearly opine that Epps-Malloy could never return to gainful employment (Dr. Williams Questionnaire), and the information he submitted did indicate various problems with Epps-Malloy's health (*id.*; Dr. Williams 1-16-96 Notes; Dr. Williams 6-14-96 Notes). For instance, Dr. Williams performed a complete physical examination on June 14, 1996, found that "sarcoidosis is her diagnosis as well as fibromyalgia," and prescribed Premarin as treatment for Epps-Malloy's fibromyalgia. (6-14-00 Dr. Williams Notes; 7-17-00 Mem. & Order at 16.) Dr. Williams, however, never performed a recent pulmonary function examination.[23] (Dr. Williams Questionnaire.) Given the failure to perform such a test as well as the contrary reports of Dr. Dev and Nurse Girado, Dr. Williams's documentation and opinion do not

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[23] Although not explicitly raised by the parties, the Court observes that Dr. Williams's notes do not provide a very thorough basis for his diagnoses. In particular, while he diagnosed Epps-Malloy as suffering from sarcoidosis and fibromyalgia following the June 14, 1996 physical, the results of this physical examination apparently did not reveal any medical problems. (6-14-96 Dr. Williams Notes.) For instance, he stated that Epps-Malloy's heart and lungs were "within normal limits." (*Id.*)

represent "overwhelming evidence" of Epps-Malloy's disability under the Plan.[24]

Having considered the more recent items of evidence, the Court must now turn to the older materials in the administrative record, dated prior to UNUM's review commencing in 1996. While defendants attack the age of these reports (Defs.' Br. at 25), Epps-Malloy asserts that they demonstrate that Epps-Malloy's conditions, namely sarcoidosis, fibromyalgia, fibromyositis, and chronic pain syndrome, were disabling under the Plan and progressive in nature, without any improvement expected. (Pl.'s Br. at 18-20.) Certain of the older medical reports clearly support a finding of total disability, at least in the past. After all, Epps-Malloy's claim for benefits was approved on the basis of this documentation. For example, Dr. Schwartz provided a rather full account

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[24] At approximately the same time UNUM received documentation from Dr. Williams, it also received submissions from Dr. Pannullo. The Court agrees with Epps-Malloy that Dr. Pannullo's submissions do not provide a sufficient basis for UNUM's decision to terminate Epps-Malloy's benefits, but such a fact does not entitle Epps-Malloy to relief in this matter given the presence of other substantial evidence justifying UNUM's termination. (See Pl.'s Br. at 23.) In its initial termination letter, UNUM justified its decision partly on the grounds of Dr. Pannullo's indication that "he [sic] sees [Epps-Malloy] yearly and that [she has] been released from his [sic] care to return to work with no restrictions or limitations." (12-31-96 Termination Letter at 1.) As the Court previously stated (7-17-00 Mem. & Order at 16), Dr. Pannullo clearly informed UNUM that she was a gynecologist and therefore was not treating Epps-Malloy for sarcoidosis. (First Dr. Pannullo Questionnaire.) While she stated that Epps-Malloy's postmenopausal replacement required no restrictions and the prognosis for Epps-Malloy's return to work were good, such statements were unconnected with any non-gynecological condition. (Second Dr. Pannullo Questionnaire.) It would therefore be unreasonable to rely on Dr. Pannullo regarding the existence of any disability based on sarcoidosis. Dr. Pannullo's responses do rule out any claim for disability on gynecological grounds, a claim admittedly never asserted by Epps-Malloy.

of his examination of Epps-Malloy, her claims, and his conclusion of total disability. (Dr. Schwartz Report at 1-3.) He also suggested that the sarcoidosis was caused by stressful activity, and stated that any individual suffering from this disease, including Epps-Malloy, would develop worse symptoms as time passes.[25] (*Id.* at 1-2.) Similarly, Drs. Kiell, Gangemi, Stein, and Thakkar as well as Couwenberg provided further details regarding Epps-Malloy's past medical condition and disabled status. (*See* Dr. Kiell Report; Dr. Gangemi Report; Dr. Stein Report; Dr. Stein Supp. Report; Couwenberg Report; Hamlet Hospital Discharge Sheet; Hamlet Hospital Medical Record.)

Even acknowledging the weight of these earlier reports, the Court still finds that UNUM's termination determination was supported by substantial evidence and neither unreasonable nor erroneous as a matter of law. No indication exists that these earlier reports were based on the results of a contemporaneously performed pulmonary function test or similar examination. Furthermore, even if sarcoidosis could persist for long periods of time in certain patients even after treatment (Pl.'s Reply Br. at 2-3 (citing Nat'l Jewish Med. &

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[25] Defendants argue that Dr. Schwartz's statements regarding sarcoidosis are inconsistent with "conventional wisdom" concerning the disease. (Defs.' Br. at 25-26.) Defendants contend that the cause of the disease "remains a mystery" and conventional wisdom, apparently also embodied in Internet materials, indicates that most patients improve without any treatment and never experience a relapse and that treatment, when required, is typically effective. (Defs.' Br. at 26.) In making such arguments, defendants go beyond providing helpful background information and seek the improper use of evidence outside the record to call into question the opinions of a physician. In any case, as Epps-Malloy contends, many of the same Internet sources relied upon by defendants, show that certain patients never recover from this disease, which in rare cases leads to serious physical ailments and even death. (Pls.' Reply Br. at 2-3 (quoting Am. Lung Assoc., *Sarcoidosis*, http://www.lungusa.org/diseases/lungsarcoido.html (last visited 10-15-01)))

Research Ctr., *Sarcoidosis*, http://www.nationaljewish.org/medfacts/sarcoid.html (last visited 10-15-01))), the Court cannot conclude that the termination of Epps-Malloy's benefits was unreasonable based on a series of reports dated several years prior to its determination.

On September 13, 1994, the administrative law judge reversed the earlier denial of Social Security disability benefits, finding that Epps-Malloy satisfied the definition of disability under the Social Security Act. (Social Security Decision at 3-5.) Epps-Malloy contends that UNUM's benefits determination was rendered arbitrary and capricious by its alleged failure to consider this Social Security Decision, particularly given the asserted similarities between the Plan and the Social Security Act. (Pl.'s Br. at 29-32.) Defendants respond that this Social Security Decision was in fact considered, and that, even if it were not, the Social Security Decision was irrelevant to its justified termination of Epps-Malloy's long-term disability benefits under the Plan. (Defs.' Br. at 33-36.)

The Court rejects Epps-Malloy's assertion that the termination of her benefits was arbitrary and capricious simply because UNUM allegedly failed to consider the Social Security Decision in its decision-making process. Even assuming that the failure to consider an adverse Social Security determination constitutes sufficient grounds to overturn an ERISA benefits determination, the Court finds that UNUM did in fact consider the Social Security Decision. Epps-Malloy's argument rests on the absence of a specific reference to this Social Security Decision in UNUM's correspondence regarding the termination of benefits and Dukes's description of the history of Epps-Malloy's claim. (Pl.'s Br. at 29-32.) Defendants, however, insist that the Social Security Decision was considered as a part of the administrative record. (Def.'s Br. at 35-36.) UNUM presumably gave this Social Security Decision some consideration

given its inclusion in the administrative record.[26] *See Conlev v. Pitney Bowes. Inc.*, 978 F. Supp. 892, 900 (E.D. Mo. 1997) ("The fact of plaintiff's Social Security Award was in the plaintiff's file with the Disability Department and was therefore presumably given some consideration by the Medical Director."), *aff'd sub nom.*, *Conley v. Pitney Bowes*, 176 F.3d 1044 (8th Cir. 1998).

But, even if UNUM considered the Social Security Decision, the Court must still determine whether a termination of

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[26] Epps-Malloy, in a footnote to her brief, appears to contend, as an alternative basis of liability, that the absence of any explicit consideration of the Social Security Decision in UNUM's correspondence violates the notice requirement of 29 U.S.C. § 1333. (Pl.'s Br. at 31 n.2.) 29 U.S.C. § 1333(1) specifies that every employee benefit plan must

> . . . provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant.

See, e.g., *Cox v. Mid-America Dairymen. Inc.*, 965 F.2d 569, 573-74 (1992) (remanding case to retirement committee due in part to unsatisfactory explanation of decision in written notices to plaintiff). The Court will not consider any potential liability of defendants under this statutory provision because of the absence of an appropriate allegation regarding this section in Epps-Malloy's Second Amended Complaint and of a full discussion of this statutory requirement by the parties.

Although not mentioned by the parties, there appears to be some question regarding the appropriate level of deference to be given possibly post hoc rationales offered to justify a denial or termination of benefits. Many of the arguments made by defendants were not explicitly stated in its correspondence with Epps-Malloy. In *Skretvedt*, the Third Circuit expressed significant concern regarding these kinds of justifications, apparently offered "for the first time in federal court." *Skretvedt*, 268 F.3d at 177 n.8. We, however, will not explore this admittedly important issue any further given the absence of specific arguments regarding this point by the parties. The Third Circuit also refrained from reaching "the question of what level of deference is owed to rationales for denying benefits under an ERISA-governed plan that a pension board presents for the first time in federal court." *Id.*

disability benefits in the face of an apparently contrary Social Security finding of total disability was arbitrary and capricious. While the Social Security Decision was not binding on any determination under the Plan, it certainly may be considered by the Court in applying the arbitrary and capricious standard, particularly when the plan's standards resemble Social Security principles. Although some decisions have indicated that Social Security determinations play no special role in an ERISA analysis, *see, e.g., Conley*., 978 F. Supp. at 900 n.4, a number of courts have emphasized the importance of these determinations to the review of a benefits decision, *see, e.g., Ladd v. ITT Corp*., 148 F.3d 753, 754-56 (7th Cir. 1998); *Kirwan v. Marriot Corp*., 10 F.3d 784, 790 n.32 (8th Cir. 1994) (citations omitted); *Dorsey v. Provident Life & Ins. Co*.,—F. Supp. 2d—, 2001 WL 1198632, at *9 n.11 (E.D. Pa. Oct. 5, 2001); *Poulos v. Motorola Long Term Disability Plan*, 93 F. Supp. 2d 926, 930-33 (N.D. Ill. 2000); *Pierce v. Am. Waterworks Co*., 683 F. Supp. 996, 1000-01 (W.D. Pa. 1988); *Cutignola v. N.Y. Tel. Co*., No. 83 Civ. 2082, 1984 WL 1324, at *4-*5 (S.D.N.Y. Dec. 11, 1984). In considering the weight to be given to a Social Security determination, the court should examine the similarities between Social Security provisions and plan language, particularly regarding the definition of disability. *See, e.g., Ladd*, 148 F.3d at 754-56 (concluding that plan and Social Security definitions of disability were essentially same and considering denial of benefits arbitrary and irrational partly based on administrative law judge's finding of total disability); *Cox v. Mid-America Dairymen, Inc*., 965 F.2d 569, 572-74 (8th Cir. 1992) (stating that plan gave administrator discretion to deny claim despite contrary Social Security determination because disability under plan was defined in more restrictive fashion but remanding matter to administrator partly because of difficult questions of plan interpretation not previously addressed by administrator); *Poulos*, 93 F. Supp. 2d at 930-33 (applying Social Security standards to

ERISA claim because plan's definition of disability was nearly identical to Social Security definition and finding denial of benefits arbitrary and capricious partly because of Social Security determination of disability). *But see, e.g., Scarinci v. Ciccia*, 880 F. Supp. 359, 365 (E.D. Pa. 1995) (comparing arbitrary and capricious standard with less deferential Social Security inquiry) (citations omitted). A plan's requirement for a participant to apply for Social Security disability benefits also bolsters the relevance of a Social Security determination, particularly if the administrator actively encourages such an application and even provides legal assistance. *Ladd*, 148 F.3d at 757 (stating that, based on logic of judicial estoppel doctrine, administrator's denial of benefits after encouraging and supporting successful social security claim is particularly problematic).

The Social Security Decision should be considered in our evaluation of UNUM's termination of benefits. As Epps-Malloy notes, clear similarities exist between the Plan and the Social Security Act. The Social Security Act defines a total disability as an "inability to engage in any substantial gainful activity," 42 U.S.C. § 423(d)(1)(A). The Plan defines such a term as "the inability of the participant to engage in any gainful employment for which the Participant is or may become reasonably qualified by training, education and experience." (Plan.) The Seventh Circuit in *Ladd v. ITT Corp.*, 148 F.3d 753 (7th Cir. 1998), found almost identical plan language defining total disability to mean "the same thing" as under the social security program, *id.* at 754. The Plan also required Epps-Malloy to apply for these Social Security benefits. (Plan.) Given these considerations,[27] the

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[27] Defendants do contend that the Social Security Decision is irrelevant because the standards under the Plan and the statutory requirements under the Social Security Act differ. (Defs.' Br. at 33-36.) Of particular significance, defendants refer to Judge Lechner's decision in *Pokol v. E.I. DuPont DeNemours & Co.*, 963 F. Supp. 1361 (D.N.J. 1997). This

Court therefore concludes that the Social Security Decision is entitled to a certain degree of weight in our analysis.

Even giving the Social Security Decision its fullest possible weight, Epps-Malloy has not demonstrated that UNUM's termination ought to be set aside by this Court. The Social Security Decision does provide perhaps the strongest support of all the evidence in the administrative record for a finding of total disability under the Plan. But, as Epps-Malloy herself acknowledges (Pl.'s Br. at 30), a Social Security determination, even if relevant and important evidence, does not estop or prevent a contrary decision by a plan administrator. *See, e.g., Madden v. ITT Long Disability Plan for Salaried Employees*, 914 F.2d 1279, 1285-87 (9th Cir. 1990) (stating that, although administrator did not consider Social Security award, decision was justified based on all of medical

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decision, while perhaps adopting a more rigorous approach to the comparison between standards than cases such as *Ladd*, does not alter our conclusion that the Social Security Decision ought to be considered. The *Pokol* court did reject plaintiff's argument that the decision to deny ERISA benefits was arbitrary and capricious because of the award of Social Security disability benefits. *Id.* at 1379-80. It distinguished between the standards, noting that the ERISA plan at issue required not only permanent disability but also, according to defendants' interpretation, the submission of objective medical evidence in support of a claim. *Id.* at 1380. The Plan at issue here, however, does not appear to require such permanent injury. (*See* Plan.) The *Pokol* court further contrasted the broad construction to be given the Social Security Act with the purposes under ERISA of the promotion of employee interests and the protection of contractually defined benefits. *Id.* While such a policy-based distinction may be relevant, a court must still consider other possible similarities between Social Security and plan principles. In any case, regardless of the *Pokol* court's analysis of the distinctions, the court further noted that the Social Security determination was not even before the administrator at the time it denied plaintiff's benefits. *Id.* at 1381. Epps-Malloy and defendants agree that the Social Security Decision was submitted to UNUM prior to the final termination of her benefits. (Pl.'s Br. at 29-32; Defs.' Br. at 33-36.)

evidence in record); *Russell v. Paul Revere Life Ins. Co.*, 148 F. Supp. 2d 392, 409 (D. Del. 2000) (stating that administrator is not bound by Social Security determination) (citations omitted); *Ferguson v. Greyhound Ret. & Disability Trust*, 613 F. Supp. 323, 325 (W.D. Pa. 1985)(stating that Social Security and workers' compensation determinations of disability do "not determine that the trustees' decision was clearly erroneous or irrational"). Even when the Social Security Decision is combined with Epps-Malloy's other submissions to UNUM, it still does not appear that UNUM's determination, supported as it was by the reports of Dr. Dev and Nurse Girado, was unreasonable, not based on substantial evidence, or erroneous as a matter of law. In fact, the weight to be given this Social Security Decision must be reduced because these two reports were not before the administrative law judge. (*See* Social Security Decision.) The report of Dr. Dev, dated May 19, 1997 (Dr. Dev Report), and Nurse Girado's evaluation, dated February 3, 1997 (Nurse Girado Comments), were not actually written until some time after the September 13, 1994 Social Security Decision (Social Security Decision).

The Court, having fully considered the administrative record before UNUM when it terminated Epps-Malloy's long-term disability benefits, finds that this determination was not arbitrary and capricious. This Court, if it had to decide this question under a de novo standard, might have found that this determination was improper. But we are not called upon to apply such a standard but to consider the termination under a highly deferential standard. While certain evidence does point to a finding of total disability under the Plan, the Court cannot say that UNUM's contrary determination was unreasonable, not supported by substantial evidence, or erroneous as a matter of law. The Court therefore will uphold UNUM's determination in this matter.

CONCLUSION

For the reasons given in this Memorandum Opinion, the Court finds that UNUM's termination of Epps-Malloy's long-term disability benefits was not unlawful under the controlling arbitrary and capricious standard. Epps-Malloy therefore is not entitled to benefits under 29 U.S.C. § 1132 (g)(1)(B). Although defendants challenge Epps-Malloy's First and Second Causes of Action insofar as they seek relief from UNUM and Merck (Defs.' Br. at 37-40), the Court need not address this question because it has found that Epps-Malloy is not entitled to any such relief even if it were available. The Court therefore will enter a judgment on the pleadings in favor of Merck and UNUM as to Epps-Malloy's First and Second Causes of Action and in favor of the Merck Plan as to her Third Cause of Action.

An appropriate Order accompanies this Memorandum Opinion.

APPENDIX D

29 U.S.C. § 1104(a)(1) (2000)

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

APPENDIX E

29 U.S.C. § 1133(2) (2000)

In accordance with regulations of the Secretary. every employee benefit plan shall—

* * *

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

APPENDIX F

29 C.F.R. § 2560.503-1(g)(1) (1997)

(g) Review procedure.

(1) Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim to an appropriate named fiduciary or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial may be obtained. Every such procedure shall include but not be limited to provisions that a claimant or his duly authorized representative may:

(i) Request a review upon written application to the plan;

(ii) Review pertinent documents; and

(iii) Submit issues and comments in writing.

APPENDIX G

29 C.F.R. §§ 2560.503-1(h)(1), 3(iii), and (4) (2004)

(h) Appeal of adverse benefit determinations.

(1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

* * *

(3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures—

* * *

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

(2)

No. 04-995

IN THE

Supreme Court of the United States

MERCK & CO., INC., UNUM LIFE INSURANCE COMPANY OF AMERICA, and MERCK & CO., INC., LONG-TERM DISABILITY PLAN FOR UNION EMPLOYEES,

Petitioners,

v.

CELESLIE EPPS-MALLOY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether an ERISA plan fiduciary commits a procedural irregularity, resulting in a less deferential standard of review to the fiduciary's benefit determination, when the fiduciary requests an independent medical examination in circumstances which suggest that the fiduciary was not being disinterested, but rather was seeking evidence to support a denial of a claim for benefits.

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STATEMENT OF THE CASE

Factual Background

In 1991, Epps-Malloy was employed as a cook and food service attendant by Merck. That year, she suffered an injury at work, and subsequently applied for long term disability benefits under the Merck Plan. Epps-Malloy was diagnosed with fibromyalgia, chronic pain syndrome, and sarcoidosis, among other conditions. Upon review of her medical records, including the results of various medical examinations, UNUM, Merck and the Merck Plan granted Epps-Malloy long term disability benefits. Subsequently, over the next four (4) years, UNUM, Merck and the Merck Plan sought and obtained updated medical information from Epps-Malloy, including reports of a physician under the employ of Merck, Dr. Stein. These reports reaffirmed Epps-Malloy's earlier diagnosis, and concluded that she had reached maximum medical improvement. Additionally, in 1994, an administrative law judge awarded Epps-Malloy social security disability benefits, retroactive to May 14, 1991, finding her to be totally disabled within the meaning of the Social Security Act.

In December, 1996, Merck, UNUM and the Merck Plan terminated Epps-Malloy's long term disability benefits. Specifically, by letter dated December 31, 1996, Dukes informed Epps-Malloy that her LTD benefits were discontinued as of January 5, 1997. In relevant part, Dukes stated that:

> With reference to your claim, please be advised that upon review of the information that has been provided, you no longer meet the definition of being unable to perform any and every duty of your occupation. . . .

> We received a document dated August 12, 1996 from Dr. Pannullo, M.D. and he indicates that he sees you yearly and that you have been released from his care to return to work with no restrictions or limitations.
>
> We received another documentation from Dr. Williams dated October 28, 1996. This document states that you can perform light duty and he is seeing you every 6 months. Medications are Beconase AQ Nasal Spray, Beconase AQ inhaler, Premarin and Elavil at bedtime. . . .
>
> Based on the medical documentation received to date there is no evidence to support that you are medically unable to perform the duties of your occupation. Therefore, we are unable to extend benefits to you beyond January 5, 1997.

See CA Appendix at p. 459. The letter also advised her of Epps-Malloy's right to appeal this determination. *Id.*

Epps-Malloy subsequently appealed UNUM's wrongful discontinuance of her LTD benefits, and requested a review of her claim by the Disability Plan Administrator. *See* CA Appendix at p. 288. Epps-Malloy indicated that, as UNUM and/or Merck already was aware, Dr. Pannullo was her gynecologist. She also stated that, as per her conversation with Dukes on November 25, 1996, she found it hard to understand that UNUM had lost all of her records. Epps-Malloy indicated that she had already sent copies of her SSA decision and award to UNUM, and that it was in any case strange that UNUM had no record of her SSA award when the Plan required her to apply for such benefits. In any event, she attached an authorization for release of information form,

along with a completed medical questionnaire form, which had been sent to her on November 25, 1996. *See* CA Appendix at p. 290. Finally, Epps-Malloy provided Dukes with the name, address and phone number of her then-current treating physician, Dr. Fred D. McQueen, Jr., M.D. *See* CA Appendix at p. 288.

In January, 1997, UNUM acknowledged receipt of Epps-Malloy's appeal. UNUM also indicated that it needed various chart and diagnostic testing notes from Dr. McQueen. *See* CA Appendix at p. 293.

By letter dated January 15, 1997, Epps-Malloy again stressed to Dukes that Dr. Pannullo was her gynecologist, and that the doctor was a female, and not a male, as was mistakenly indicated in Dukes' prior correspondence to her. Epps-Malloy reiterated that her new physician was Dr. McQueen, and she provided a list of her current medications. *See* CA Appendix at p. 295.

By letter dated January 23, 1997, UNUM requested that Dr. McQueen provide it with "all medical files, diagnostic testing, x-ray results, etc." *See* CA Appendix at p. 297.

Dr. McQueen promptly responded to UNUM's request. On or about January 30, 1997, he faxed UNUM his diagnosis and prognosis of Epps-Malloy's condition, along with his chart notes from her January 7, 1997 examination. *See* CA Appendix at p. 299. He also faxed UNUM various medical documents pertaining to Epps-Malloy's December 23, 1995 admission to Hamlet Hospital. *See* CA Appendix at p. 301.

In the statement and notes Dr. McQueen forwarded to UNUM, he indicated that:

> **She has severe sarcoidosis. She is permanently and totally disabled by Social Security. . . . She has been dx'ed with fibrosyositis and she is on hormone therapy, Premarin and PROventil inhaler. . . . She has skin lesions appearing on her legs from the sarcoid . . . I do not feel it in her best interest to be under any stress due to triggering sarcoid remission . . . Permanently and totally disabled. . . .**

See CA Appendix at p. 299 (emphasis added).

Further, Dr. Thakkar, M.D., in his December, 1995 discharge summary from Epps-Malloy's stay at Hamlet Hospital, indicated that she had a history "of sarcoidosis and hysterectomy and rectal bleeding for which we got more information." Once again, these notes were forwarded by Dr. McQueen to UNUM. *See* CA Appendix at p. 301.

Curiously, despite Dr. Williams' and Dr. McQueen's clear findings that Epps-Malloy was totally disabled and afflicted with sarcoidosis and fibromatosis, UNUM forwarded Dr. McQueen's note to a registered nurse for further review. After consultation with UNUM representative Dukes, nurse Ann Girardo speculated about the thoroughness of Dr. McQueen's analysis in a handwritten note dated February 3, 1997. *See* CA Appendix at p. 312.

By letter dated February 4, 1997, Dukes informed Epps-Malloy that "we have reviewed the additional information that you recently sent us and regret it was not sufficient to reverse out previous decision." Apparently, UNUM ascribed more weight to the "findings" of nurse Girardo, who never examined Epps-Malloy, than to the medical diagnoses of her treating physicians, Dr. Williams, M.D. and Dr. McQueen,

M.D. Dukes went on to state that Epps-Malloy's file would be forwarded to UNUM's quality review section in Maine for an impartial review, as provided for by ERISA. *See* CA Appendix at p. 314.

One day later, on February 5, 1997, Dukes informed Epps- Malloy that "there will be a delay in the appeal process due to the fact that Merck & Company has requested an Independent Medical Exam." Dukes advised Epps-Malloy further that she would subsequently be apprised of the time, date and location of this exam. *See* CA Appendix at p. 317.

On May 8, 1997, Epps-Malloy was examined by a Dr. Gautam Dev, M.D. In Dr. Dev's May 19, 1997 report, he concluded as follows:

> My impression of Mrs. Epps-Malloy is that her symptomatology is not commensurate with her clinical presentation. Considering the normal pulmonary function test and near normal arterial blood gas, I have a difficult time ascribing sarcoidosis as a cause of her symptomatology. She appears to be emotional and I cannot reliably exclude malingering behavior. *On the contrary, the endobronchial sarcoid may be leading to persistent cough and dyspnea.* Chronic sinusitis can also exacerbate a respiratory condition and lead to some degree of shortness of breath. The patient's impaired cardiac status is also a possibility and *an exercise stress test might be able to help answer some of the unanswered questions.*

See CA Appendix at p. 319 (emphasis added).

Finally, on June 4, 1997, Dukes informed Epps-Malloy that her appeal had been denied. Dukes explained that:

> We have received the report from Gautam Dev, MD. The report dated 5/18/97 indicates Dr. Dev performed a Pulmonary functions test and a arterial study (blood gas). The results of these exams were normal. Therefore, your claim will remain terminated.

See CA Appendix at p. 321.

Procedural History

Subsequently, plaintiff Epps-Malloy alleged that defendants Merck and Company, Inc. ("Merck"), UNUM Life Insurance Company of America ("UNUM"), and the Merck and Company, Inc. Long Term Disability Plan for Union Employees ("Merck Plan") violated the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. Section 1132(a)(1)(B), by terminating their long term disability benefits.

In her complaint before the United States District Court for the District of New Jersey, Epps-Malloy sought reinstatement of her long term disability benefits, and past due benefits which were wrongfully denied, and reasonable costs and attorneys fees, among other relief.

Subsequently, UNUM, Merck and the Merck Plan filed a motion for summary judgment. In pertinent part, the District Court denied this motion, noting that Dr. Dev's report was "far from conclusive." The matter was then scheduled to proceed to a bench trial. *See* CA Appendix at p. 11.

On December 27, 2001, the District Court, by Judge Mary L. Cooper, entered judgment in favor of the UNUM, Merck and the Merck Plan. In so doing, the District Court utilized the traditional arbitrary and capricious standard of review for UNUM. Merck and the Merck Plan's actions, rather than a heightened standard of review, and concluded that their actions were not arbitrary or capricious. *See* App. 21a-64a.

Epps-Malloy filed a timely appeal from the District Court to the United States Court of Appeals for the Third Circuit. In its decision, the Third Circuit reversed the judgment of the District Court and remanded the matter for a new trial on the merits. The Third Circuit reached this decision for two reasons. First, the Third Circuit concluded that the District Court failed to apply the appropriate standard of review. Reviewing the record, the Third Circuit found that there was evidence of procedural bias that warranted the application of a moderately heightened arbitrary and capricious standard of review. Specifically, at the appeal stage of the claim, at a point in time where every piece of evidence pointed to the fact that Epps-Malloy was totally and permanently disabled within the meaning of the Plan, Merck intervened in the claims process and ordered an IME by a physician of its won choosing.

The Third Circuit explained that:

> This situation arguably has a quality to it that undermines the administrator's claim to the deference normally owned to plan fiduciaries. Given how favorable the record was to Epps-Malloy prior to Dr. Dev's examination, the most natural inference is that by intervening and

> ordering the retention of Dr. Dev, thus seeking evidence to counter Epps-Malloy's physicians' evaluation, Merck was not being a disinterested fiduciary.

See App. 15a.

At the same time, the Third Circuit stressed that its decision should not deter responsible fiduciaries from seeking additional medical information, and that courts would not penalize such fiduciaries for seeking such information at the appropriate stages of the claims determination process. *Id.* at 16a.[1]

Second, the Third Circuit also held in the alternative that it would in any case set aside the District Court's decision on the grounds that it did not adequately address the defendants' denial of Epps-Malloy's benefits claim in view of her diagnosis of fibromyalgia. *See* App. 17a-18a. Petitioners do not seek review of this aspect of the Third Circuit's decision.

The Third Circuit subsequently denied Petitioners' request for rehearing and rehearing en banc. *See* App. 19a.

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1. The Third Circuit also noted the possibility that Epps-Malloy's status as a former employee might also trigger a heightened level of review, depending on the Plan's funding mechanism. For example, such a heightened level of review might apply where Merck paid plan benefits out of its general operating funds. *See* App. 14a. The Third Circuit noted that the District Court on remand could allow the parties to supplement the record on the manner in which the Plan was funded, and it left the resolution of this issue to the sound discretion of the District Court. *Id.* at 14a, n.5.

ARGUMENT

The Petition for a Writ of Certiorari should be denied.

I. The Third Circuit's decision does not conflict with the decisions of this Court or of other Courts of Appeals.

Petitioners' primary argument in favor of certiorari being granted rests upon an overstatement of the reach of the Third Circuit's decision. Petitioners repeatedly make the assertion that the Third Circuit effectively held that a fiduciary's request for an IME – in and of itself – warrants the imposition of a heightened level of review of the fiduciary's claim determination. They then go on to argue that such a decision conflicts with the decision of other courts of appeal, some of which have noted that the fiduciary's use of an IME might weigh against an inference of bias in the circumstances of the specific case under review, as well as the decision of this Court in *Black & Decker Disability Plan v. Nord,* 538 U.S. 822 (2003), which noted that the opinions of treating physicians may not be entitled to additional deference. Such arguments are completely without merit.

The Third Circuit *did not* hold that the use of an IME by a fiduciary automatically mandates the use of a heightened level of review of the fiduciary's claim determination. Instead, the court took great pains to stress that it was "the circumstances in which Merck made this request [that] necessarily raise an inference of bias. At the time of the request, every piece of evidence in Epps-Malloy's record – the opinions of two doctors (Dr. Williams and McQueen), a consistent medical history, and an SSA determination that she was totally disabled –supported her contention that she

was disabled." *See* App. 14a-15a. In addition, Merck requested the IME at the appeals stage, rather than the initial determination stage. *Id.* at 15a. In light of this record, the "most natural inference" was that Merck was simply intervening in an attempt to uncover evidence that would support a denial of Epps-Malloy's appeal. As the court stressed, such conduct suggests that "Merck was not being a disinterested fiduciary" entitled to "the deference normally owed to plan fiduciaries." *Id.*

It flows from this decision that in some cases similar to the case at bar, requesting an IME at a time which suggests the purpose of the request is to defeat a particular claim for benefits may well result in the application of a heightened level of scrutiny of the fiduciary's claim determination. At the same time, it is also true that in other, different circumstances, a fiduciary's request for an IME will not have that effect. Indeed, the Third Circuit itself emphasized that it "trust[ed] that courts will not penalize plan administrators for seeking independent medical examinations at appropriate stages of the claims determination process." *See* App. 16a.

Under these circumstances, the bogeyman raised by Petitioners simply does not exist. A court within the Third Circuit may, depending upon the circumstances surrounding the request for an IME, find that it is evidence of procedural bias, or, conceivably, that it suggests no bias was present. It all depends upon the facts of the particular case. Consequently, there is no reason for this Court to intervene in this matter and grant the Petition for Writ of Certiorari, as the danger raised by Petitioners is completely illusory.

II. The Third Circuit's decision does not conflict with any interest in uniformity, fair claims procedures and/or the encouragement of ERISA plans.

For the reasons set forth *supra,* the Third Circuit's decision does not radically change the legal landscape for ERISA plans. It simply ensures that, at least within the Third Circuit, fiduciaries will act with more care in deciding to order IMEs when their apparent purpose is to defeat a claim for benefits. Indeed, the Third Circuit itself disclaimed any general intent to deter fiduciaries from ordering IMEs, and correctly noted that "[f]or a responsible fiduciary, we trust that the incentive to collect enough information to make a responsible claims determination will outweigh the incentive to avoid requesting more information in the hopes of obtaining the most deferential standard of review." *See* App. 16a.

CONCLUSION

For all of the aforementioned reasons, the Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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